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I Commissions and committees of inquiry

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Thursday, December 12th, 1963.

1964

VOLUME

1. PUBLIC HEARINGS

DATE

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December 12, 1963



VERBATIM REPORTING SERVICE
OFFICIAL REPORTERS
TORONTO, ONTARIO

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PROVINCE OF ONTARIO

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THE CO-OPERATIVE MEDICAL SERVICES FEDERATION OF

ONTARIO

Appears: Mr. R. A. G. Stewart, M.D.

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PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

SUBMISSION OF THE CO-OPERATIVE MEDICAL SERVICES

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Miss HELEN CARPENTER

Mr. DALTON J. CASWELL

Mr. A. ROY COULTER

Dr. R.J. GALLOWAY

Dr. JOHN HAMILTON

Mr. W.S. MAJOR

Miss HELEN McARTHUR

Mr. P.J. MULROONEY

Mr. CARMAN A. NAYLOR

Mr. HARRY SIMON

Mr. J.L. WHITNEY

Mr. L.E. TURNER

-- Secretary



PROVINCE OF ONTARIO

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--- On commencing at 10:00 a.m. other member to answer.

Will you please identify your spokesman, and

SUBMISSION OF THE CO-OPERATIVE MEDICAL SERVICES

FEDERATION OF ONTARIO

Appearances: Mr. R.A. Stewart Dr. R. Forshaw
Mr. Wilson McCoig Mr. W. Bradshaw
Mr. E. Schofield
Mr. A. McLauchlin Mr. Lorne Evans

THE CHAIRMAN: Members of the Enquiry have

received and studied the brief you submitted. In accordance with the guide for participation in hearings that was mailed to you, it will not be necessary for you to read your brief, but you do have an opportunity to emphasize or enlarge upon its conclusions or recommendations.

Members of the Enquiry may ask you questions on the statements or recommendations submitted in your brief, but you are not to be subjected to examination or cross-examination by other persons.

It is not our intention to debate your suggestions or recommendations, nor to state the views of this Enquiry on them. Consequently, any opinions expressed in questions asked or statements made by members of the Enquiry are intended for clarification only.

As stated in the instructions, one person is to act as your spokesman. However, if the spokesman feels that another member is better qualified to answer a specific question from a member of the Enquiry, the spokesman may receive the



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1 Chair's permission to request the other member to answer.
2 things of this Will you please identify your spokesman, and
3 then proceed. Agriculture and the Co-Operative Union, this
4 movement started. The members of the press have requested a copy
5 of your brief, and if you have copies with you, perhaps you
6 will hand them to the members of the press at the conclusion
7 of your submission. wider field of activity.

8 MR. STEWART: Mr. Chairman and Commissioners;
9 On behalf of the Co-Operative Medical Services Federation of
10 Ontario groups in Ontario, I would first of all like to con-
11 gratulate you all on your appointment to this very important
12 commission, and to say that we are glad to meet with you this
13 morning to discuss these problems. to other fields, as we have
14 outlined in our Our Federation consists of 31 co-operative groups
15 throughout the province, providing in varying degrees medical
16 insurance, and other types of service that the members require.
17 Hospital Service These services include, among others we act as
18 an official collecting agency for the Ontario Hospital Services
19 Commission. We service a term life insurance program through
20 Co-Operative Life of Regina, and we service the Blue Cross
21 Supplementary Hospitalization Program at the moment. some of our
22 deliberations. Co-Operative Medical Services groups were
23 organized throughout the province in the late '40's, basically
24 as groups of rural, self-employed people. This ruralization
25 started because of a tendency for such things as were available



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as groups of rural, self-employed people. This ruralization

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1 at that time to be limited to groups, employed groups, and
2 things of this nature. So that in co-operation with the
3 Federation of Agriculture and the Co-Operative Union, this
4 movement started in rural areas, basically to provide hospitali-
5 zation at that time.

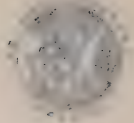
6 It now includes many urban groups and individuals
7 and covers a much wider field of activity.

8 We came under the supervision of the Department
9 of Insurance in 1951, which did give a large degree of super-
10 vision, and the resultant stability to our organizations. Since
11 that time the function on behalf of the members has extended
12 towards the objective of providing for total health care.

13 We have entered into other fields, as we have
14 outlined in our brief. The emphasis changed towards this total
15 health care as compared with hospitalization, as we were in the
16 beginning. This, of course, was forced upon us when the Ontario
17 Hospital Services Commission took over actively the ward care
18 treatment in hospital.

19 We are members of the Ontario Federation of
20 Agriculture and of the Co-Operative Union of Ontario, and
21 support those organizations, and seek their help in some of our
22 deliberations.

23 Members of our delegation here this morning
24 include members of our Federation Board, representing both the
25 technical side of our organization, that is the managers of the



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1 local groups, and the director function in our organizations.
2 Our organizations are -- each one is an autonomous group, with
3 its own Board of Directors, locally elected, and they retain
4 control of the policy and the financial program of the organiza-
5 tion.

6 We are also widely represented as related to the
7 geographic area that we cover here this morning, and as
8 President of the Federation, and immediate Past President of
9 the Lanark Co-Operative Medical Service, which is from the far
10 east, Wilson McCoig, Manager of the Kent Co-Operative Services,
11 from Chatham, immediate Past President of the Federation. From
12 the far west, Bob Forshaw, the Vice-President of our Association,
13 and Director of Wellington Co-Operative Services, from Guelph,
14 hasn't arrived yet. We expected him to be here this morning,
15 but probably he is having some difficulty. Bill Bradshaw on
16 my extreme left here is the Manager of Lambton Co-Operative
17 Services, from Toronto, also from pretty far west. Art
18 McLauchlin here is the Director of the Quinte Co-Operative
19 Medical Services. Quinte is one of the organizations which
20 cover a group of counties, and it includes all of Prince
21 Edward County, Lennox and Addington, Hastings, and the left
22 half of Frontenac is sort of between there and Durham.

23 So that we have this, not only the two sides of
24 our organization represented in our delegation, we are also well
25 represented geographically.

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1 Ted Schofield, our Technical Manager, is probably
2 in difficulties this morning, like a lot of other people. He
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4 hope he will get here before you get us into too much difficulty.

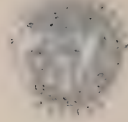
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6 want to emphasize a few of the points we will raise. We
7 haven't attempted to go into too much technical detail in this
8 brief. It's more in the line of philosophy relating to the
9 principles in the field of health services, and is intended to
10 give you some of the thinking of this widely scattered group
11 of people who are providing medical services basically for
12 themselves. It is a self-help program.

13 The brief, I think, attempts to give you a little
14 bit of the thinking of these people with relation to the
15 extension of services in the Province of Ontario.

16 A few of the salient points that we want to
17 bring before you are shown in the Summary, on page 10 of the
18 brief pretty well, but we might just run over quickly the points
19 there.

20 Firstly we are concerned about retaining and
21 having protected the right of self-determination in the areas
22 of extent of benefits and kinds of service that we may provide
23 for ourselves in addition to such compulsory programs as we
24 would be required under the terms of Bill 163 to carry.

25 This is something that we would like to have the



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1 opportunity to continue. We have had negotiations with other
2 professional groups, other than the medical profession, and
3 we are working in that direction as quickly as we can, towards
4 the field of total health care. Now, we would hope that Bill
5 163 is just a step in that direction, one of the mechanisms that
6 might be used to more adequately meet the requirements of the
7 people of this great province, and we know that it's a very
8 complicated, and very extensive program to get into, and we
9 would hope that this is one of the mechanisms tending in that
10 direction.

11 We are concerned that on any program in which
12 the government is an active participant that there be equal and
13 impartial treatment of all carriers in the settlement of
14 accounts.

15 We are concerned that within our program, where
16 we are working on a schedule of fees as established by the
17 professional groups, that some provision be made that we are
18 sure of reasonable notification of changes in the schedule of
19 fees, so that we don't get into financial difficulties. This,
20 we feel, isn't very clearly spelled out in Bill 163, and has
21 given us some concern.

22 We have participated in a program of bursaries
23 for medical students, and it's our feeling that some provision
24 probably should be made within the concept of this program that
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1 assist in the education of medical students.

2 We, as I have stated earlier, are under the
3 supervision of the Department of Insurance, and we are a little
4 concerned about the references to Medical Carriers Incorporated
5 in the Bill 163. It seems to us that the functions, at least
6 as outlined, as far as we can see might very well be co-
7 ordinated with the Department of Insurance. We have a relatively
8 high proportion of older age people within our organizations,
9 and we feel that there shouldn't be discrimination against the
10 older age groups, particularly in the self-employed segments
11 of our population.

12 We, as co-operatives of course, are concerned
13 about the right of the consumers to participate in such
14 programs as they wish to develop in their own right, so that
15 we may in fact control the operation of our organizations in
16 a democratic way.

17 I know we are rushed this morning, and I don't
18 want to take any more time. We will try to enlarge on these
19 items as you see fit, and I did notice you stated that we could
20 sort of shop out these questions if we feel it in the best
21 interest.

22 This, Mr. Chairman, I think, is the extent of
23 our opening statement.

24 THE CHAIRMAN: Thank you Mr. Stewart. Some of
25 the members of the Enquiry have indicated the desire to ask

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1 questions. Mrs. Aylen?

2 MRS. AYLEN: Mr. Stewart, I would like to
3 congratulate you very much on this very good brief. It covers
4 quite a wide field.

5 I understand from what you said that the greater
6 percentage of the participants live in rural areas?

7 MR. STEWART: In the beginning it was practically
8 all rural, not necessarily rural farms, but villages and towns.

9 MRS. AYLEN: As opposed to big cities?

10 MR. STEWART: Yes, but recently we have had quite
11 a movement, shall we say, these labour groups, and what could
12 only be called purely urban groups.

13 MRS. AYLEN: If a subscriber gives up the farm
14 and goes to the city, is he still entitled to benefits?

15 MR. STEWART: Yes, there is complete portability.

16 MRS. AYLEN: Do you find that there is greater
17 utilization of the plan when a person moves to a larger city?

18 In other words, when they have more services
19 available, do they use them?

20 MR. STEWART: I wouldn't think that that would
21 apply. I might ask Mr. McCoig here, Mr. Chairman. He has a
22 composite urban rural group within his organization.

23 MRS. AYLEN: Maybe you aren't prepared to answer
24 that. It's just something --

25 MR. STEWART: No, I am not.

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apply. I might ask Mr. McColl here, Mr. Chairman. He has a

composite urban rural group within his organization.

MRS. AYLEN: Maybe you aren't prepared to answer

MR. STEWART: No, I am not.



1 MRS. AYLEN: Because you are recommending a
2 pretty comprehensive plan here, and what I am wondering is, the
3 people who live in smaller centers might not be able to get
4 services that they are paying for?

5 Now, that was just one of my comments. I also
6 noted that you are very ---

7 THE CHAIRMAN: Mrs. Aylen, Mr. Stewart indicated
8 that possibly Mr. McCoig could answer that.

9 MR. McCOIG: Mr. Chairman, I've had within a
10 week or two one year's experience with a union labour group of
11 some one thousand members, and I cannot see any difference,
12 looking over their claims, starting January 1st, 1963, as
13 against the rural portion, because we have them separated on
14 our books, both premium-wise and claims-wise, and I cannot see
15 any appreciable difference.

16 THE CHAIRMAN: And the union group would be in
17 an urban location?

18 MR. McCOIG: Yes, Windsor, Sarnia and Chatham.

19 MR. STEWART: I think that what Mr. McCoig says
20 would be generally correct. There would be very little
21 difference in the utilization.

22 MRS. AYLEN: The second thing, I notice that
23 you favour part of the fee going toward education. Do you
24 believe that medical and nursing education should be the
25 responsibility of a medical care plan, or should it come under



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1 some other department?

2 MR. STEWART: We have within our organiza-
3 tion, as I think we have outlined here, devoted a percentage
4 of our premium income towards the promotion of educational
5 facilities, or the education of medical people. This is
6 merely an extension of this thinking, and we are concerned about
7 the necessity of stimulating medical education, and we have
8 done it within our organization, and we feel it is useful, and
9 are recommending that some plan of utilization of a portion of
10 the premiums might be made.

11 MR. WHITNEY: Do you load the premium with five
12 cents, or ten cents, for this purpose?

13 MR. STEWART: No.

14 MR. WHITNEY: Or do you determine something
15 gratuitously, and at your own discretion, at the end of the
16 year?

17 MR. STEWART: It is decided at the annual
18 general meeting of our Federation, and up until this year it
19 was determined as a percentage of premium income at the local
20 level, and this year, when it was accepted by all our con-
21 federation units, it was put into the Federation budget, and
22 now becomes part of the dues.

23 MRS. AYLEN: You started out with a much simpler
24 plan than you have right now. Is that right?

25 MR. STEWART: Yes.

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2 MR. STEWART: We have within our own organiza-
3 tion, as I think we have outlined here, devoted a percentage
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10 the premiums might be made.

11 MR. WHITNEY: Do you load the premium with five
12 cents, or ten cents, for this purpose?

13 MR. STEWART: No.

14 MR. WHITNEY: Or do you determine something
15 gratuitously, and at your own discretion, at the end of the

16
17 MR. STEWART: It is decided at the annual
18 general meeting of our Federation, and up until this year it
19 was determined as a percentage of premium income at the local
20 level, and this year, when it was accepted by all our con-
21 federation units, it was put into the Federation budget, and
22 now becomes part of the dues.

23 MRS. AYER: You started out with a much simpler
24 plan than you have right now. Is that right?



1 MRS. AYLEN: When you extended the benefits,
2 did you consult the subscribers, or just get requests from
3 them?

4 MR. STEWART: We have an annual meeting every
5 year in our counties, at which their desires are made known.
6 Sometimes, in the interests of speeding the thing up, the
7 Directors go ahead and make some extensions to the coverage,
8 but it all has to be approved at the next annual meeting.

9 MRS. AYLEN: And are you able to assess the
10 cost?

11 MR. STEWART: Yes, we have built up statistics
12 within our Federation that enable us to determine what the cost
13 likely is, and then we go ahead on an experimental basis, and
14 adjust the rates if necessary.

15 DR. HAMILTON: I wonder if I might come back to
16 a question Mrs. Aylen asked, about the availability of service
17 in rural areas.

18 You have 31 member groups. Is this true?

19 MR. STEWART: That's right.

20 DR. HAMILTON: Could you tell me what the dis-
21 tribution is? Are they all in the southern part of Ontario?

22 MR. STEWART: No, they cover the whole part of
23 southern Ontario. Now, we do provide service in northern
24 Ontario, through Bruce and some of Bruce County, and some of
25 those northern central counties, but other than that the whole

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MR. STEWART: No, they cover the whole part of

southern Ontario. Now, we do provide service in northern

as northern central countries, but other than that the whole



1 of southern Ontario is covered by county organizations.

2 DR. HAMILTON: So that really you do not extend
3 into the area north of Lake Superior or far west?

4 MR. STEWART: Not with autonomous organizations
5 as such. We do provide service in those areas.

6 DR. HAMILTON: To individual subscribers?

7 MR. STEWART: Yes, through our Bruce County
8 Co-Operative Medical Services, and the manager of Bruce County
9 is here with us this morning, Mr. Chairman, if we could ask
10 him just what the situation is.

11 THE CHAIRMAN: It is quite in order, Mr. Stewart.

12 MR. LORNE EVANS: Mr. Chairman, by request of
13 the Department of Insurance a number of years ago, we were
14 requested to go up and rather take over the three organizations
15 in Manitoulin, East Algoma and the Temiskaming areas. Our
16 Board of Directors saw fit to go along with this, and we have
17 ever since that time went up, and we do provide services to that
18 area smaller to what we do in Bruce County, and it is apparently
19 quite satisfactory to the people up there.

20 DR. HAMILTON: And there's no difficulty in
21 making these services available?

22 MR. EVANS: No.

23 DR. HAMILTON: And they are just as extensive
24 as the services available to the subscribers in Southern
25 Ontario?



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DR. HAMILTON: And there's no difficulty in

making these services available?

DR. HAMILTON: And they are

as the services available to the subscribers in Southern



1 MR. EVANS: We give them exactly the same
2 services we do to our people in Bruce County.

3 DR. HAMILTON: Are there any limitations on the
4 service provided?

5 MR. EVANS: Well, no, as I say --

6 MR. STEWART: By geographic area, do you mean?

7 DR. HAMILTON: No, just limitation to service
8 provided by your organization.

9 MR. WHITNEY: The contract.

10 MR. STEWART: We have very specific contracts,
11 yes.

12 DR. HAMILTON: What does it exclude?

13 MR. EVANS: Well, there actually isn't anything
14 excluded. It is similar to the services in our Bruce County.
15 I mean, we haven't got into dental services yet, nor optometrical,
16 nor chiropractic, but so far as medical services are concerned,
17 they are provided just the same.

18 DR. HAMILTON: But you don't provide the services
19 of a chiropractor, nor an optometrist?

20 MR. EVANS: That is right.

21 MR. STEWART: We've come to an agreement with
22 the Ontario Association of Chiropractors, whereby a county may
23 now enter into an agreement with the Association for the coverage
24 of chiropractic services. We are at the moment engaged with the
25 Optometrists and the Osteopaths, and this is what we call a bulk

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1 purchase of service, and it's a quite complicated arrangement,
2 but the chiropractic is in effect in quite a number of our
3 counties right now.

4 Now, the only other limitation, through our
5 major medical we have a program of including any medical
6 expenses which aren't included in our surgical contract, for
7 instance, and we pay 80% up to \$5,000.00 on an overall major
8 medical program, as we call it, and we have a limitation there
9 of a certain deductible, and depending on what other contract
10 they have with us, it may be \$50.00, \$200.00, or \$300.00. It
11 varies a little bit from one county to another, but beyond that
12 we, through our major medical, agree to pay up to 80% of
13 catastrophic expenses, up to \$5,000.00.

14 We have within our Federation a pooled arrange-
15 ment whereby we sort of re-insure individual counties' risks,
16 and we have set an objective of \$700,000 as a reserve against
17 this pool, and we have exceeded that now.

18 So that we have this protective device built
19 into our program.

20 Is this what you are meaning by limitations?
21 I'm not sure whether I am meeting your question.

22 DR. HAMILTON: No, you are providing a lot of
23 information that we do want. Yes, thank you very much.

24 Would you provide the Commission with a sample
25 of your contract?

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1 MR. STEWART: Oh, yes. Now, when you say our
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3 county has its own, and they vary.

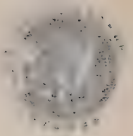
4 This autonomous character of our organization,
5 which of course gives a very high degree of local control,
6 results in a bit of variation, but under the general direction
7 of the federation.

8 Now, we have some contracts here.

9 DR. HAMILTON: What I really was asking was if
10 there was any kind of medical service that you did not cover?

11 MR. STEWART: Most of our counties now have what
12 we call our comprehensive coverage, which covers home and office
13 calls in medical and surgical. Then we have, as I say, in
14 addition to that our major medical, in which we bulk everything
15 else, home nursing service. We've had to eliminate nursing
16 service in hospital, because it was developing very difficult
17 relations between hospital administrators, nurses, ourselves,
18 and doctors. So, in most cases, this is not quite a hundred
19 per cent I think, but in most cases we have eliminated nursing
20 in hospital, on the assumption that necessary nursing is now
21 provided by the Commission. We were getting into all sorts of
22 difficulty in trying to determine what was necessary, and what
23 was not, and we just ruled that out.

24 DR. HAMILTON: But do you provide nursing service
25 in the home?



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DR. HAMILTON: But do you provide nursing service



1 MR. STEWART: Yes, under our major medical we
2 provide any necessary nursing service when ordered by the
3 doctor.

4 We include drugs, and any additional medical
5 expenses. Many of our counties do not get paid full specialist
6 rates under the surgical program, but any excess over and above
7 what we pay under our general contract, it goes into our major
8 medical, and becomes part of it.

9 So that it is a very comprehensive coverage.

10 DR. HAMILTON: But there's a great deal of
11 variety in the kind of coverage that may be purchased in the
12 different counties?

13 MR. STEWART: I wouldn't say a great deal of
14 variety. I say there's some, and we can't just say that we have
15 a Federation contract, but within the last couple of years
16 practically all of our groups have accepted the recommendation
17 of the Federation, and we have pretty active uniformity all
18 across this province.

19 DR. HAMILTON: Do you pay the full fees then?

20 MR. STEWART: Yes.

21 DR. HAMILTON: I wasn't clear when you said that
22 sometimes you don't pay the full specialist fees?

23 MR. STEWART: No, we don't pay the full specialist
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25 General Tariff, the General Schedule of Fees. This is something



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1 that is actively being considered right at the moment, but
2 it's a very complicated field to try to determine, as you well
3 know, the impact of specialist services in all the various
4 fields of activity, and at the present most of our contracts
5 are limited to the general schedule of fees.

6 DR. HAMILTON: The general practitioners'
7 schedule of fees?

8 MR. STEWART: Yes, unless there is nothing in
9 the schedule for a general practitioner. There are some
10 operations which apparently aren't done by general practitioners,
11 and therefore it's a specialist rate only.

12 DR. HAMILTON: And you pay that specialist rate?

13 MR. STEWART: We pay that.

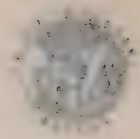
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15 specialist rate?

16 MR. STEWART: We're not obligated to pay the
17 specialist rate. We will put it that way.

18 DR. HAMILTON: There is, then, a limitation to
19 the service available. Is this not right?

20 MR. STEWART: Well, any of these things
21 certainly have to have some limitations.

22 Now, as I said, the excess, if there is a
23 specialist charge of which we can only pay the general tariff
24 under our contract, the excess of that can go into our major
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1 DR. HAMILTON: He has to buy another contract?

2 MR. STEWART: That is another contract, yes.

3 DR. HAMILTON: Thank you very much.

4 MR. STEWART: It's a progression of contracts.

5 Most of our counties have maybe four contracts at various
6 extents of coverage, you see, to try to meet the financial
7 ability and desires of our members.

8 DR. HAMILTON: Thank you very much.

9 THE CHAIRMAN: I have a follow-up question to
10 one that Dr. Hamilton asked.

11 You answered, I believe, that some of your
12 counties include chiropractic services?

13 MR. STEWART: Yes.

14 THE CHAIRMAN: Do you have cost records that
15 could be made available to the Enquiry on the additional cost
16 for the chiropractic?

17 MR. STEWART: Yes sir.

18 MR. WHITNEY: Do you cover oral surgery?

19 MR. McCOIG: Yes sir, we do. Might I add
20 further, this is a contract of the Kent Co-Operative Medical
21 Services, and in the Extended Medical Plan we allow ten
22 osteopathic treatments, with a limitation of \$3.00 per treatment.

23 This was on the Department of Insurance insistence
24 that we put this limitation in, but each person on the contract
25 has ten osteopathic treatments per year at \$3.00 per treatment.



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1 This is the extent of our liability. It's built
2 right into the contract.

3 MR. STEWART: I've been informed that Bruce
4 County does pay specialist fees when it's a referral from a
5 general practitioner.

6 Again, we do get a bit of variation in it. These
7 counties are pretty jealous of their rights in making these
8 little changes, and some of them are bolder than others in
9 extending the contracts, and we do have certain variations.

10 This is something that is before the Federation
11 right at the moment, as to a recommendation that we could make,
12 in a general form, that we could safety make to all of our
13 counties, our members.

14 MR. MAJOR: Mr. Stewart, it's been emphasized
15 that there is a variety in the 31 plans. However, this variety
16 isn't going to preclude you from following the present sort of
17 set-up of Bill 163, where there is going to be a plan available.
18 All 31 of your members will be able to handle that one standard
19 plan?

20 MR. STEWART: Yes sir. I think that we are
21 pretty well beyond that standard plan in most of our counties
22 at the moment, and if we have to segregate that as a specific
23 plan, well, that can be done, but it's included in most of our
24 counties at the moment.

25 MR. MAJOR: You were asked about the cost of



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MR. MAJOR: You were asked about the cost of



1 people moving from a rural area to a city area, and Mr. McCoig
2 told us that he didn't see any difference in utilization, but
3 you didn't answer whether or not there was a difference in
4 cost for a participant?

5 MR. STEWART: Do you mean in the charges that
6 are made for various services?

7 MR. MAJOR: I am talking about the cost per
8 participant who receives medical care. You have a cost per
9 participant in your organizations. You get so much money per
10 participant per month, and against this you have to get a cost
11 per participant, and in a city of 100,000 or more the schedule
12 of fees is higher than it is in a rural area.

13 I want to know whether you have seen a lowering
14 of utilization when you went to a big city, so that your cost
15 was standard?

16 MR. STEWART: I understood that the schedule
17 of fees ---

18 MR. MAJOR: There's a different schedule of
19 fees for home calls in an area with a population of a hundred
20 thousand or more in the Province of Ontario than there is in a
21 small area.

22 Did you have a lower utilization, or what was
23 the difference in cost for those people living in an area of
24 more than a hundred thousand population, and those living in a
25 rural area?

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1 MR. BRADSHAW: I have not a city in my area of
2 more than a hundred thousand. Sarnia is 52,000.

3 MR. MAJOR: In other words, there's no movement
4 let us say, noticeable in your organization from a rural area to
5 a large city area, where you may see a difference in utilization
6 and cost?

7 MR. STEWART: We have no indication of that,
8 sir, at the moment.

9 MR. MAJOR: Fine. That's what I was getting at.
10 Your major medical plan, which is an additional
11 plan to your base plan, and if you don't understand my termin-
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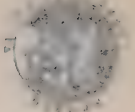
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16 a \$50 deductible, and 80% co-insurance, and let's for argument's
17 sake, say that you have now received bills from physicians
18 which you have paid on the base plan.

19 You are now prepared to apply a \$50 deduction,
20 which will be computed on all the services rendered, or
21 obtained under the major medical plan, and then you are prepared
22 to pay the excess in medical fees. Correct?

23 MR. STEWART: Any specialist fees.

24 MR. MAJOR: As long as they are medical?

25 MR. STEWART: That's right, yes.



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1 MR. MAJOR: Do you find this particular
2 application of insurance inflationary on medical fees?

3 MR. STEWART: We haven't found that. Do you
4 mean the fact that we are willing to cover over and above the
5 schedule in another way?

6 MR. MAJOR: Sure. You set up a pot of money to
7 pay medical fees, which if it isn't paid under circumstance A
8 fully, you will provide it under circumstance B.

9 Now, have you found this to have any type of
10 inflationary aspect on the medical fees of your clients?

11 MR. McCOIG: Mr. Chairman, in answer to Mr.
12 Major, when he exceeds this contract it's still the O.M.A.
13 tariff. This is the extent of our liability.

14 MR. MAJOR: In other words, you don't recognize
15 in your major medical plan a medical fee in excess of the
16 O.M.A. tariff?

17 MR. STEWART: I was speaking of specialist rates.

18 MR. McCOIG: First on the expanded medical, which
19 is drawn up on the G.P. tariff, then the difference between the
20 G.P. tariff and the specialist tariff is all that comes in
21 here.

22 MR. MAJOR: Well, let's take another example,
23 and we'll see how this works.

24 So now you have \$150 for procedure X listed in
25 the tariff under general tariff, and you call a specialist.



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application of insurance inflationary or medical fees?

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mean the fact that we are willing to cover over and above the

schedule in another way?

MR. MAJOR: Sure. You set up a pot of money to

pay medical fees, which if it isn't paid under circumstances B,

fully, you will provide it under circumstance B.

Now, have you found this to have any type of

inflationary aspect on the medical fees of your clients?

MR. McGOIG: Mr. Chairman, in answer to Mr.

Major, when he exceeds this contract it's still the O.M.A.

tariff. This is the extent of our liability.

MR. MAJOR: In other words, you don't recognize

in your major medical plan a medical

O.M.A. tariff?

MR. STEWART: I was speaking of specialist rates

MR. McGOIG: First on the expanded medical, which

is drawn up on the G.P. tariff, then the difference between the

G.P. tariff and the specialist tariff is all that comes in

here.

MR. MAJOR: Well, let's take another example,

and we'll see how this works.

So now you have \$150 for procedure X listed in

the tariff under general tariff, and you call a specialist.



1 The specialist does this job, and this job costs \$250, and
2 under the hands of the specialist, and, for argument's sake,
3 we will now be a little more tough on you. The deductible
4 allows \$200 in this particular major medical application. You
5 don't pay anything more than that. You aren't covering any
6 medical fee at all in those circumstances, above that specialist
7 fee, are you?

8 MR. McCOIG: If the total family expenses for
9 the contract year for every person on the contract, including
10 drugs, medicines, ordered or given by a doctor, the specialist,
11 all lumped together, they make one claim at the end of the
12 contract year. The first deductible is applied, whichever it
13 is. It can be three ways, and 80% of the balance.

14 MR. MAJOR: And this is the first application
15 of the deductible?

16 MR. McCOIG: Yes.

17 MR. MAJOR: So you wouldn't cover it?

18 MR. McCOIG: No, not in that specific case.

19 MR. MAJOR: So that if this family happened to
20 be unfortunate enough not to get any other kind of health
21 services covered by your major medical plan, then they would
22 be out the \$200 that they would have to pay the specialist?

23 MR. McCOIG: The difference you quoted is just
24 one hundred.

25 MR. MAJOR: I am sorry. One hundred.

The specialist does this job, and this job costs \$250, and under the hands of the specialist, and, for argument's sake, we will now be a little more tough on you. The deductible allows \$200 in this particular major medical application. You don't pay anything more than that. You aren't covering any medical fee at all in those circumstances, above that specialist

MR. MCGOUGH: If the total family expenses for the contract year for every person on the contract, including drugs, medicines, ordered or given by a doctor, the specialist all lumped together, they make one claim at the end of the contract year. The first deductible is applied, whichever is it. It can be three ways, and 80% of the balance.

MR. MATOR: And this is the first application

of the deductible?

MR. MCGOUGH: Yes.

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MR. MATOR: So that if this family happened to

be unfortunate enough not to get any other kind of health

services covered by your major medical plan, then they would

be out the \$200 that they would have to pay the specialist?

MR. MCGOUGH: The difference you quoted is that

MR. MATOR: I am sorry. One hundred.



1 Why did you find it necessary, why should it
2 come about that you are now a Federation, you are all working
3 under a common Board, with sub-Boards, that you have this
4 variation of deductibles on your major medical of \$50 to \$300?

5 This is quite a spread in the application of an
6 insurance principle.

7 MR. STEWART: The variation in the deductible
8 has been a contentious question through the years, but you can
9 understand that it depends to a certain extent to what is
10 covered under the basic contract.

11 The extent of protection that is given now in
12 our own county, we still have a major medical as a basis for
13 membership, for instance, that they don't need to have any
14 other contract. This is a ten dollar per family contract, a
15 very limited coverage, but it does give this catastrophic
16 element to this.

17 MR. MAJOR: What is the deductible on that?

18 MR. STEWART: Four hundred. Now, you can see
19 where all of these expenses may be included, that the risk is
20 considerably greater. Now, if they have in hospital medical,
21 for instance, then the deductible is three hundred. If they
22 have the full, comprehensive, under which we are obligated to
23 pay most of the medical bills under other contracts, then we
24 feel we are a little safer with a lower deductible, and this may
25 go down as low as fifty dollars, because the majority of the bills

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 come about that you are now a Federation, you are all working
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MR. MALON: What is the deductible on that?

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 considerably greater. Now, if they have in hospital medical,
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 pay most of the medical bills under other contracts, then we
 feel we are a little safer with a lower deductible, and this is



1 are then paid under the comprehensive, and aren't included in
2 the major medical.

3 Now, this gives a pretty adequate coverage. If
4 a person has the comprehensive contract and a \$50 deductible,
5 on the average it's a pretty comprehensive type of coverage,
6 but this is the basis for the variation in our deductible,
7 depending what the county has in its basic contract.

8 MR. MAJOR: I follow you sir. You say on page
9 one of your brief:

10 "At the present moment we feel that the 31
11 County Medical Co-Operatives that make up our
12 Federation are providing for care of the highest
13 possible degree through the mechanism of in-
14 surance."

15 And you apparently have equated the mechanism
16 of insurance to some kind of a formula basis, that it's good
17 insurance to deduct \$400 if they haven't got any other kind of
18 insurance.

19 Is that the way you've approached this applica-
20 tion of an insurance principle?

21 MR. STEWART: Well, this, of course is at the
22 option of the member. We take the stand that if a member
23 feels all they can pay is \$10, and they want some coverage,
24 then this will protect them against the big losses, but if they
25 want the other coverage, we try to make it available.



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Now, this gives a pretty adequate coverage. If a person has the comprehensive contract and a \$50 deductible, on the average it's a pretty comprehensive type of coverage, but this is the basis for the variation in our deductible, depending what the county has in its basic contract.

MR. MALONE: I follow you sir. You say on page one of your brief:

"At the present moment we feel that the County Medical Co-Operatives that make up our Federation are providing for care of the highest possible degree through the mechanism of insurance."

And you apparently have equated the mechanism of insurance to some kind of a formula basis, that it's good insurance to deduct \$400 in insurance.

Is that the way you've approached this application of an insurance principle?

MR. STURGEON: Well, this, of course is at the option of the member. We take the stand that if a member feels all they can pay is \$10, and they want some coverage, then this will protect them against the big losses, but if they



1 MR. MAJOR: In this particular county co-
2 operative that we're talking about, one of the 31, each member
3 of this would have the choice of taking the deductible he
4 wants?

5 MR. STEWART: Right.

6 MR. WHITNEY: It's a Federation.

7 MR. MAJOR: This is not an overall application.
8 The individual has his choice to take the type of insurance
9 policy he wants, whether the \$400 deductible, on a base plan
10 or a \$50 deductible?

11 MR. STEWART: This is exactly the philosophy of
12 the co-operatives, as outlined in the first line of our summary,
13 that we would like to see this retained, of the members having
14 some option of deciding, not immediately saying "You have to
15 take everything, or nothing", but a little bit of option that
16 will leave some of this responsibility on the part of the
17 members.

18 MR. MAJOR: Does your interpretation of Bill 163
19 lead you to believe that they would not have this option?

20 MR. STEWART: No, not at the present time.

21 MR. MAJOR: On page 2, paragraph 6 you say:

22 "Our own experience with a functioning Major
23 Medical Plan has shown that it is both practical
24 and highly feasible to provide very broad
25 coverages to our members in such areas of cost as



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WASHINGTON, D.C. 20540

MR. MAJOR: In this particular country co-

operative that we're talking about, one of the 31, each member

of this would have the choice of taking the deductible he

wants?

MR. STEWART: Right.

MR. WEINSTEIN: It's a deduction.

MR. MAJOR: This is not an overall application.

The individual has his choice to take the type of insurance

policy he wants, whether the \$100 deductible, or a base plan

or a \$50 deductible?

MR. STEWART: This is exactly the philosophy of

the co-operatives, as outlined in the first line of our summary.

that we would like to see this retained, of the members having

some option of deciding, not immediately saying "You have to

take everything, or nothing", but a little bit of option that

will leave some of this responsibility on the part of the

members.

MR. MAJOR: Does your interpretation of BILL 10

lead you to believe that they would not have this opti-

MR. STEWART: No, not at the present time.

MR. MAJOR: On page 2, paragraph 6 you say:

"From our experience when a questioning Major

Medical Plan has shown that it is both practical

and highly feasible to provide very broad

coverage to our members in such areas of cost



1 "drugs, ambulances, appliances, nursing bills,
2 and many other items ---".

3 Could you give me a few of these many other
4 items, so that we can have some knowledge of what we're
5 talking about?

6 MR. McCOIG: Reading from the contract, Mr.

7 Chairman:

8 "Physicians, surgeons and general practitioners
9 services at rates not exceeding the scale
10 recommended by the Ontario Medical Association
11 in schedule of fees published in January, 1962;
12 and
13 Services performed other than within a hospital
14 by a registered nurse who is not a member of the
15 immediate family of the member and who does not
16 ordinarily reside in the member's home, and
17 whose services were ordered by the attending
18 physician as a necessary part of the patient's
19 treatment, at rates not higher than the pre-
20 vailing rates at the place where the services
21 are rendered, and in no case higher than the
22 rate for comparable services in Ontario; and
23 Ambulance services from the place of injury or
24 onset of illness to the nearest place or places
25 for treatment; and



1 "Laboratory services, special drugs ---".

2 MR. MAJOR: You don't limit those laboratory
3 services? They are in any laboratory, hospital, government?
4 Would you accept a charge from a government laboratory in
5 this plan?

6 MR. McCOIG: "---and ordered by the attending
7 physician as necessary for treatment of any
8 illness or injury."

9 MR. MAJOR: Regardless of who performed them?

10 MR. McCOIG: That's right.

11 "Laboratory services, special drugs, appliances,
12 therapy or related services administered by a
13 registered physiotherapist and ordered by the
14 attending physician as necessary for treatment
15 of any illness or injury."

16 MR. MAJOR: Just as a matter of interest, and
17 in an attempt to ascertain the anti-selection, the possibility
18 of use, how many ambulances and nurses in private practice are
19 there in Manitoulin Island?

20 It's one thing to put into a contract what you
21 are going to offer the public. It's another thing whether
22 the public will be able to get it or not.

23 Now, on Manitoulin Island, I am well acquainted
24 with the area, there may be a nurse there, but she's most likely
25 a farmer's wife. If she is available, that's fine. If she is



"Laboratory services, special drugs ---".

MR. MAJOR: You don't limit those laboratory

services? They are in any laboratory, hospital, Government?

Would you accept a charge from a Government laboratory in

this place?

MR. McCOIG: "---and ordered by the attending

physician as necessary for treatment of any

illness or injury."

MR. MAJOR: Regardless of who performed them?

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the public will be able to get it or not.

Now, on Manitowish Island, I am well acquainted

with the area, there may be a nurse there, but she's not likely

a farmer's wife. If she is available, that's fine. If she is



1 not, you have to get some ambulance service.

2 What is the anti-selection? What is the
3 possibility of utilization of your medical plan in an area like
4 Manitoulin Island, or Elliot Lake, or Temiskaming even?

5 MR. STEWART: I would expect that if there were
6 a serious accident on Manitoulin Island there would be an
7 ambulance available, or someone who would provide a comparable
8 service that would have to be paid for.

9 I quite agree that there is a great difference
10 in the availability of these services, but I would think that
11 these people, within certain limits, would certainly get these
12 services.

13 MR. MAJOR: Well, the grade of service comes
14 from the hinterland down to the populated area?

15 MR. STEWART: Yes.

16 MR. MAJOR: This is, by and large, an insurance
17 principle that is continuously applicable, 24 hours a day,
18 365 days a year, so that we could come down from the utilization
19 cost figures we discussed previously, from the rural area into
20 the metropolitan area of Toronto, and undoubtedly there will
21 be a difference. Theoretically there just has to be a
22 difference, doesn't there?

23 On page 3, paragraph 9, I would like you to
24 explain it, so that we fully understand?

25 MR. STEWART: I am quite sure you understand it,



not, you have to get some ambulance service.

What is the end-selection? What is the

possibility of obtaining a good medical plan in an area like

Manitowish Island, or Elliot Lake, or Torchington even?

MR. STEWART: I would expect that if there were

a serious accident on Manitowish Island there would be an

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cost figures we discussed previously, from the rural area into

the metropolitan area of Toronto, and undoubtedly there will

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On page 3, paragraph 9, I would like you to

explain it, so that we fully understand

MR. STEWART: I am quite sure you understand it.



1 but you probably want me to say so. This is one of the key
2 points in our brief and something that has been of great
3 concern to us and it obviously refers to the 90% payment on
4 behalf of some carriers in connection with medical services.
5 As long as this is done in a voluntary way and carried out as
6 it has been in the past, while we seriously object to it, we
7 haven't been able to bring ourselves to feel that maybe there
8 was any just objection to it. But it is our feeling that if
9 the government becomes actively involved in the payment of
10 premiums on behalf of people to carriers, as is our interpreta-
11 tion of the concept of Bill 163, then there could be a great
12 injustice develop through this procedure. The basis of our
13 protest here is that as long as it is done by a specific group
14 within its own organization, then maybe they are just doing
15 the same thing as maybe we are doing -- trying to protect
16 themselves against certain factors. But it is our contention
17 that if and when government becomes actively involved and sub-
18 stantially involved in the payment of premiums on behalf of
19 individuals to carriers, as we consider the concept of Bill 163,
20 then it can be an iniquitous sort of thing and it could create
21 a great difference of the effects on the operations of various
22 carriers. I do not think there is anything more I can say in
23 this connection.

24 MR. MAJOR: Does your interpretation of Bill 163
25 lead you to believe that the government is going to pay a



1 You probably want me to say so. This is one of the key
2 points in our brief and something that has been of great
3 concern to us and it obviously refers to the 50% payment on
4 behalf of some carriers in connection with medical services.
5 As long as this is done in a voluntary way and carried out as
6 it has been in the past, while we seriously object to it,
7 haven't been able to bring ourselves to feel that maybe there
8 was any just objection to it. But it is a feeling that if
9 the government becomes actively involved in the payment of
10 premiums on behalf of people to carriers, as in our interpreta-
11 tion of the concept of Bill 100, then there could be a great
12 protest here is that as long as it is done by a group
13 within its own organization, then maybe they are just doing
14 the same thing as maybe we are doing -- trying to protect
15 themselves against certain factors. But it is our contention
16 that if and when government becomes actively involved and sub-
17 stantially involved in the payment of premiums on behalf of
18 individuals to carriers, as we consider the concept of Bill 100
19 then it can be an independent sort of thing and it could create
20 a great difference in the effects on the operations of various
21 carriers. I do not think there is anything more I can say in
22 this connection.

23 MR. MAJOR: Does your interpretation of Bill 100



1 premium to carriers?

2 MR. STEWART: Yes.

3 MR. MAJOR: It does?

4 MR. STEWART: It enables the government to do
5 that, that they may provide full premiums for those who are
6 indigents and partial premiums for those who can establish that
7 they need some assistance.

8 MR. MAJOR: Without referring to the Bill, I
9 think it reads something like this, that the government may
10 purchase for the indigent, or the near indigent, medical services
11 insurance.

12 MR. STEWART: Right.

13 MR. MAJOR: But it does not say that it is going
14 to pay a carrier for this?

15 MR. STEWART: The whole concept, our concept
16 of Bill 163, is that it is the intention of the government to
17 leave this business in the hands of the carriers; therefore,
18 if they purchase this service on behalf of individuals, who
19 else can they purchase it from?

20 MR. MAJOR: Do you think it is not compatible
21 with the government approach and the tax approach to buy
22 medical care for the indigents on the best possible tender it
23 can get?

24 MR. STEWART: I am prepared to segregate the
25 handling of the indigents with those near indigents. I think

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MR. MAJOR: Without referring to the Bill, I

think it reads something like this, that the government may

purchase for the indigents the best medical services

that it can get.

MR. STEWART: Yes.

MR. MAJOR: It does not say that it is going

to pay a carrier for this?

MR. STEWART: The whole concept, our concept

of the Bill is that it is the intention of the government to

have the best medical services that they

if they purchase this service on behalf of individuals, who

else can they purchase it from?

MR. MAJOR: Do you think it is not compatible

with the government approach and the tax approach to pay

medical care for the indigents on the best possible tender it

can get?

MR. STEWART: I am prepared to segregate the

handling of the indigents with these near indigents. I think



1 the handling of the indigents at the present moment is a very
2 satisfactory way of handling it; but it seems to me we are
3 getting into a completely different field if we start to
4 partially pay premiums. I think there is going to be a com-
5 pletely different concept here and this is a field actually
6 that we would expect. We can't tell. I am saying that if the
7 government does actively participate in the payment of premiums
8 to carriers, then there must be some other regulations to put
9 every carrier on a uniform basis.

10 MR. MAJOR: Your great fear is that if the
11 government does pay premiums to carriers that the 90% payment
12 that is now in effect under the doctor sponsored services plans
13 is a sort of injustice against the rest of the carriers?

14 MR. STEWART: That is correct.

15 MR. MAJOR: In your organization, do you have
16 contracts with physicians that bind them to do certain things
17 under certain circumstances?

18 MR. STEWART: Not to my knowledge.

19 MR. MAJOR: Are you bound to pay the physician
20 directly for the service he renders, or can you pay your
21 subscriber?

22 MR. STEWART: In most cases, I think the doctor
23 is paid. I wouldn't be surprised if there are some cases where
24 the patient pays the bill and sends it to us; but we are required
25 to pay it.

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satisfactory way of handling it; but it seems to me we are

getting into a completely different field if we start to

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1 MR. MAJOR: Is the doctor paid by an assignment
2 from the subscriber or do you pay the doctor directly?

3 MR. WHITNEY: He means as a matter of contract,
4 what is your arrangement?

5 MR. STEWART: I do not think that is covered.

6 MR. McCOIG: Mr. Chairman, we are licensed as a
7 co-operative. I understand that it is a very thin line, but
8 we pay the doctors without an assignment. When I say "we", I
9 am speaking about Kent Co-Operative. But this applies now
10 pretty well across the province where we have claim cards almost
11 identical with the doctor sponsored plans. Our cheques go
12 directly to the doctor.

13 MR. WHITNEY: Made out only to the doctor?

14 MR. McCOIG: Only to the doctor, except in very
15 exceptional circumstances.

16 MR. WHITNEY: There is nothing in your contract
17 or your claim card which is signed by the insured?

18 MR. McCOIG: No.

19 MR. WHITNEY: That directly authorizes you to
20 pay on his behalf?

21 MR. McCOIG: No.

22 MR. WHITNEY: Nothing in the contract?

23 MR. McCOIG: No; unless some doctor that is not
24 in the immediate area of our members uses the Canadian Medical
25 Association claims sheet where the assignment comes in. But, by



MR. MASON: Is the doctor paid by an assignment from the subscriber or do you pay the doctor directly?

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or your claim card which is signed by the insured?

MR. WHITNEY: That directly addresses you to

MR. MCCOIG: No; unless some doctor that is not in the immediate area or our messengers near the Canadian Medical



1 and large, it is our own claim cards that we are now using.

2 MR. MAJOR: Mr. Stewart, when you pay this
3 doctor directly, is he obliged to take your payment as a full
4 and final settlement for the services rendered to the sub-
5 scriber?

6 MR. STEWART: No; we have nothing of that
7 nature.

8 MR. MAJOR: We have built up in this province,
9 and in many of the provinces in Canada, two systems. They
10 developed because of want. One system is the application of
11 the indemnity insurance service; the other system is the
12 application of service through a contract with a physician.
13 There are over two million people in this province covered by
14 these contracts. Do you feel that because of Bill 163 that
15 you should destroy this service principle for these over two
16 million people in this province because of the supposed in-
17 compatibility between the indemnity principle and the service
18 principle?

19 MR. STEWART: At the moment, I would not be
20 prepared to say that it would destroy this -- necessarily
21 destroy this.

22 MR. MAJOR: It would. That is why I wanted you
23 to see if you could tell us, as an enquiry, what your opinion
24 is, should your interpretation of the Act be put into force,
25 so that there would be no difference or no special privilege



... is he obliged to take your payment as a full
 final settlement for the services rendered to the sub-

MR. STEWART: Yes; we have nothing at that

MR. MAJOR: We have better up in this province,

in many of the provinces in Canada, two systems. They
 are based because of what, one system is the application of
 the indemnity insurance service; the other system is the
 application of service through a company with a physician.
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 these contracts. Do you feel that because of this I should
 destroy this service principle for those over two
 million people in this province because it was supposed to

... stability between the indemnity principle and the service
 principle?

MR. STEWART: At the moment, I would not be

... to say that it would destroy this -- necessarily

MR. MAJOR: As would. That is why I wanted you

... see if you could tell us, as an employer, what your opinion
 ... of the Act be put into force?



1 given, as you express it?

2 MR. STEWART: I think we would be satisfied if
3 it were decided that everybody should pay 90%.

4 MR. MAJOR: Now, paragraph 10 on page 3, you
5 suggest for all of the people who are covered by Bill 163, the
6 standard plan, that the payment of the amount by the patient
7 or by the patient's carrier to the doctor should discharge the
8 liability of the patient, or that of the carrier. In other
9 words, you are inferring here -- or, should I put it this way
10 -- are you inferring that the insurance industry is going to
11 decide when the doctor has had the final payment of his bill?

12 MR. STEWART: This is the implication of the
13 statement, sir.

14 MR. MAJOR: Do you think that is a fair implica-
15 tion in respect to the other professions that are in this
16 province, like the lawyers and, considering their fees, the
17 plumbers and the electricians? They are in a professional
18 status, as far as fees are concerned.

19 THE CHAIRMAN: Mr. Major, I do not think we are
20 going to argue the case. They have expressed their opinion.

21 MR. STEWART: This, I think, if I might say so
22 is, again, a feeling that we have, depending on the extent that
23 the government becomes involved in these things. If the
24 government is going to become very actively involved in this
25 sort of thing, I think it puts a completely different complexion

given, as you express it?

MR. STEWART: I think we would be satisfied if

MR. MAJOR: Now, paragraph 10 on page 3, you

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MR. STEWART: This is the implication of the

MR. MAJOR: Do you think that is a fair implication

tion in respect to the other professions that are in this
province, like the lawyers and considering their fees, the
plumbers and the electricians? They are in a professional
status, as far as fees are concerned.

THE CHAIRMAN: Mr. Major, I do not think we are

going to argue the case. They have expressed their opinion.
MR. STEWART: This, I think, if I might say so

is, again, a feeling that we have, depending on the extent that
the government becomes involved in these things. If the
government is going to become very actively involved in this
sort of thing, I think it puts a completely different complexion



1 on the whole relationship. And I think this is what we are
2 pointing out, that certainly if the government were paying
3 premiums on behalf of certain individuals, I think they would
4 want to have some assurance that the services that would be
5 provided for those premiums would, in effect, cover what it
6 says it will, without any uncertainty about it. Now, we know
7 that in the normal practice of medicine there is a great
8 variation in the fees and one of the factors is in the estima-
9 tion of one's ability to pay. Over the years this has, no
10 doubt, been a good thing because there are, obviously, people
11 who can't afford to pay and the doctor must make it up someplace.
12 But if it gets into the position where the doctor is assured
13 of his payments, then I think it puts a completely different
14 complexion on it and this is all evolving from the proposed
15 participation of government in this program, that we are going
16 to have to take a fresh look at a lot of these things and this
17 is what we are implying in this section, Mr. Chairman.

18 MR. MAJOR: That is fine. But I think that your
19 statement is hitting at the very roots of a democratic
20 principle, that we individuals in this society are worth as
21 much as we can make; otherwise, you would not have professional
22 services which you are now getting. The incentive must be
23 there. If you are going to limit one profession, you are
24 going to soon degrade that profession because the incentive
25 won't be there.

on the whole relationship. And I think this is what we are pointing out, that certainly if the government were paying premiums on behalf of certain individuals, I think they would want to have some assurance that the services that would be provided for those premiums would, in effect, cover what it says it will, without any uncertainty about it. Now, we know that in the normal practice of medicine there is a great variation in the fees and one of the factors is in the estimation of one's ability to pay. Over the years this has, no doubt, been a good thing because there are, obviously, people who can't afford to pay and the doctor must make it up somehow. But if it gets into the position where the doctor is assured of his payments, then I think it puts a completely different complexion on it and this is all evolving from the proposed participation of government in this program, that we are going to have to take a fresh look at a lot of these things and this is what we are implying in this section, Mr. Chairman.

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1 THE CHAIRMAN: I do not think we want to pursue
2 this.

3 MR. STEWART: This, again, is a question of the
4 proposed government participation in this field. They do not
5 get into many of the other fields, but if they did, they would
6 have to take a look at the concepts in regard to them.

7 MR. MAJOR: I cannot debate this with you. Now,
8 on page 4, paragraph 11, about six or seven lines from the
9 bottom, you say:

10 "We are quite willing and ready to make these
11 sacrifices ..."

12 What sacrifices will you have to make under this set-up?

13 MR. STEWART: We are not sure because we do not
14 know what is going to happen. All we say here is that we are
15 prepared, if necessary, to go in this direction, if it seems
16 in the general interest, and all we are asking is that other
17 people be prepared to do likewise. We haven't the foggiest
18 idea of what is going to come out in the way of medical services.
19 I know this is not a very satisfactory answer.

20 THE CHAIRMAN: Probably what you mean there is
21 "We are prepared to co-operate".

22 MR. STEWART: To co-operate, yes. We would be
23 losing a certain degree of our autonomy if the government comes
24 in and says you must provide this contract and you must not
25 charge more than this for it, and this sort of thing. We are



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What commitments will you have to make under this act?

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and says you must provide this contract and you must not

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1 going to certainly have to lose a certain degree of our autonomy.

2 MR. MAJOR: Mr. Stewart, on page 5 you state
3 "there is no provision in this current Bill for the assistance,
4 in a financial sense, of the vast majority of the population
5 of this Province ..." What are you inferring there?

6 MR. STEWART: In Section 13?

7 MR. MAJOR: At the top of page 5, the first
8 three lines.

9 MR. STEWART: Well, under the Ontario Hospital
10 Plan, it was envisaged that the Federal Government and the
11 Provincial Government and the participating member would share,
12 relatively equally, the cost of premiums and this is just
13 pointing out that there is no provision here in the vast
14 majority of the population for the government to pay any
15 specific part of the cost of medical care.

16 MR. MAJOR: In other words, what you want is not
17 a tax support for the indigent and the marginal income person;
18 you want some tax support for every citizen, regardless of his
19 financial status?

20 MR. STEWART: No. We do not say that. We say
21 there is no provision for it and this is where we refer to the
22 question of financing education and this is a little bit of a
23 philosophical approach, I suppose, in that part of this premium
24 might be made available; it would participate, in a certain
25 measure, in the larger field of activity. This is a philosophical

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MR. MAJOR: Mr. Stewart, on page 5 you state

"there is no provision in this current Bill for the assistance

in a financial sense, of the vast majority of the population

of this Province..." What is your inference there?

MR. STEWART: In relation to?

MR. MAJOR: At the top of page 5, the first

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MR. STEWART: Well, under the Ontario Health

Plan, it was envisaged that the Federal Government and the

Provincial Government and the participating members would share

relatively equally, the cost of operations and that is, that

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question of financing education and this is a little bit of a

philosophical approach, I suppose, in that part of this program

might be made available; it would participate, in a certain

measure, in the larger field of activity. This is a philosophical



1 approach, pure and simple.

2 MR. MAJOR: But do you think it practical? As
3 I gathered, from your statement, and I think you verified it,
4 you feel that there should be more tax support for the citizens
5 of the province generally?

6 MR. STEWART: No. We haven't said that, I do
7 not think, anywhere in the brief.

8 THE CHAIRMAN: I wouldn't interpret that this
9 way. They are pointing it out there, but they are not saying
10 that there should be.

11 MR. MAJOR: In paragraph 13, you are suggesting
12 that the system of developing medical bursaries out of insurance
13 premiums should be carried on. Why medical bursaries? Why not
14 bursaries for nurses, osteopaths, chiropractors, statistical
15 bureaux to keep the statistics, research, and so on? If you
16 are going to set up, out of insurance premiums, a certain amount
17 of money for medical bursaries, where are you going to stop?

18 MR. STEWART: This might be extended to other
19 fields; but, at the moment, we are dealing with medical
20 services. We are not dealing with anything else.

21 MR. MAJOR: Back in your brief you have got a
22 major medical plan and you are making a representation to this
23 Commission on the basis that you feel there should be a broad
24 approach to health care.

25 MR. STEWART: That was an explanation of the

approach, pure and simple.

MR. MAJOR: But do you think it practical? As

I gathered, from your statement, and I think you verified it,

you feel that there should be some tax support for the citizens

of the province generally?

MR. STEWART: No. We haven't said that, I do

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MR. STEWART: That was an explanation of the



1 function and the activities of our groups. Now, when we come
2 into specific recommendations we are dealing with the concept
3 under Bill 163 which deals only with the medical profession.

4 MR. MAJOR: You feel it would be fit and proper
5 to put into the premium a certain amount of money for medical
6 bursaries?

7 MR. STEWART: That is what we are suggesting.

8 MR. MAJOR: On page 6, paragraph 15, about the
9 middle of the paragraph, you say:

10 "We would feel most reluctant to participate in
11 such an organization if its duties were to
12 extend beyond the two aforementioned areas."

13 And those two areas you have explained above: The fixing of
14 maximum premiums; ~~the open enrollment periods~~. What fears are you
15 talking about here? What duties have you got in mind that you
16 would fear?

17 MR. STEWART: An internal interference with our
18 program and our organizations which is, I think, a philosophical
19 approach to this and we do not feel that Medical Carriers
20 Incorporated could be justified on the basis of what is set up
21 in Bill 163, but we are fearful of what other duties they might
22 be given. We do not know what they might be but we are just
23 fearful. This Bill 163 appears to be so inadequate in advising
24 us in any way how this might be developed. We can't see any
25 justification for Medical Carriers Incorporated within the



question and the activities of our groups. Now, when we come into specific recommendations we are dealing with the concept under Bill 163 which deals only with the medical profession.

MR. MAJOR: You feel it would be fair and proper to put into the premium a certain amount of money for medical insurance?

MR. STEWART: That is what we are suggesting.

MR. MAJOR: On page 6, paragraph 15, about the

middle of the paragraph, you say:

"We would feel more reluctant to participate in such an organization if its duties were to extend beyond the two aforementioned areas."

And those two areas you have explained above: "the fixing of maximum premiums; the open enrollment method. What fears are you talking about here? What duties have you got in mind that you would fear?"

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1 concept that is outlined in Bill 163; therefore, we feel there
2 must be something else -- pooling, and this sort of thing, and
3 we do not know how it would work out.

4 MR. MAJOR: Would you fear pooling?

5 MR. STEWART: In some circumstances, depending
6 how it was set up. We do our own pooling, as far as that is
7 concerned.

8 MR. MAJOR: That is the point. You pool. Why
9 wouldn't you be prepared to pool on the standard plan?

10 MR. STEWART: We do not know what the provisions
11 of it would be and, being a small organization, we are always
12 fearful that we would be, probably, absorbed or something like
13 that.

14 MR. MAJOR: The mathematical approach to insurance
15 pooling is pretty standard. It would work much the same way
16 as you are doing now. Now, let us come down a little bit.

17 MR. STEWART: Some of the suggestions that we
18 have heard in regard to pooling have made us a little fearful of
19 it. Let us put it that way.

20 MR. MAJOR: Supposing there was come about a
21 mandatory pooling arrangement; what would any of us be able to
22 do about it? Have you any answer for that?

23 MR. STEWART: No. We would have to look at it
24 when it became mandatory.

25 MR. MAJOR: At the bottom of paragraph 15 on page



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have heard in regard to pooling have made us a little fearful of

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MR. MAJOR: Supposing that we were to do a

mandatory pooling arrangement; what would any of us be able to

do about it? Have you any answer for that?

MR. STEWART: No. We would have to look at it

when it became mandatory.

MR. MAJOR: At the bottom of paragraph 15 on page



1 six, and this is a little follow-up to what we have just talked
2 about, Medical Carriers Incorporated, where you say that you
3 would be happier if this thing were supervised by the Depart-
4 ment of Insurance. Are you intimating there that the Depart-
5 ment of Insurance should have the control and the privilege of
6 setting premium rates?

7 MR. STEWART: We think it can be done through
8 them, just as well as any other group.

9 MR. MAJOR: Do you think so?

10 MR. STEWART: Yes.

11 MR. MAJOR: In other words, the government can
12 set the rates for this plan that they are talking of?

13 MR. STEWART: I think they will anyway.

14 MR. MAJOR: You are crystal-gazing?

15 MR. STEWART: Yes, I know.

16 MR. MAJOR: Thank you.

17 THE CHAIRMAN: Are you finished, Mr. Major?

18 MR. MAJOR: No. I have one more question, Mr.
19 Chairman. On page 7, about six or eight lines from the bottom
20 of the page and to get you on the track I will read it to you:

21 "...the most cogent fact is that in most cases
22 the employer will participate in the cost of the
23 insurance, thus making it more readily available
24 to his employees while the self-employed must
25 pay the full burden of their insurance costs

six, and this is a little following to what we have just talked about, Medical Care's Incorporated, when you say that you would be required in this thing were supervised by the Department of Insurance. Are you indicating there that the Department of Insurance should have the control and the privilege of setting premium rates?

MR. CHAIRMAN: We think it can be done through

them, just as well as any other group.

MR. MALONE: Do you think

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MR. MALONE: In other words, the government can

set the rates for this plan and they are taking care

CHAIRMAN: I think that will be all right.

MR. MALONE: You are

CHAIRMAN: Yes, I know

CHAIRMAN: Are you finished, Mr. Malone?

MR. MALONE: No, I have one more question, Mr.

Chairman. On page 7, about six or eight lines from the bottom

of the page and to get you on the ground I will read it to you:

The most urgent fact is that in most cases

the employer will participate in the cost of the

insurance, thus adding it more readily available

to his employees while the self-employed must

the full burden of their insurance costs



1 "themselves."

2 I am not quite sure. My interpretation of what you said is
3 that an employee in an organization where the employer is paying
4 part of the cost, he is getting it free -- is this right --
5 where the fellow that has to pay his own cost is not getting it
6 free? He has to pay the full shot?

7 MR. STEWART: We have run into situations where
8 we have lost members, or failed to get them, because of these
9 employer contributions. For example, I think the Federal
10 Government insurance plan, as nearly as I can figure out, the
11 rates that the members must pay themselves are just a little bit
12 less than what we charge for the same service. It is a little
13 less. It is enough that they recognize it. But, in addition
14 to that, the Federal Government pays 50%; so that as far as the
15 member is concerned, he is getting insurance for less than what
16 we can provide it for. But, certainly from the insurance
17 companies' standpoint and from the Federal Government's stand-
18 point, this is not so. I think it is pretty well explained
19 here.

20 MR. MAJOR: This was union negotiated?

21 MR. STEWART: Yes, I know.

22 MR. MAJOR: And would you feel that you could
23 convince a union member that he was further ahead by taking it
24 this way or taking it in cash in his cheque?

25 MR. STEWART: No. I wouldn't expect that we

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that an employee in an organization where the employer is paying part of the cost, he is getting it free -- is this right -- where the fellow that has to pay his own cost is not getting it free? He has to pay the full amount?

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MR. MAJOR: And would you feel that you could convince a union member that he was further ahead by taking it this way or taking it in cash in his cheque?

MR. STEWART: No. I wouldn't expect that we



1 could do anything.

2 THE CHAIRMAN: I think they have stated an
3 opinion here and they are entitled to do so.

4 MR. STEWART: We are just pointing out here that
5 there is an added burden in this whole field of medical in-
6 surance on the part of the self-employed, who must pay the whole
7 shot for their premiums. Probably the influence of contributions
8 through industry or government may tend to even inflate the rates
9 which are charged for these programs; but there does seem to be
10 a situation in there where the self-employed are actually
11 penalized in this program.

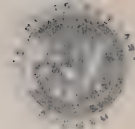
12 MR. MAJOR: Thank you very much, Mr. Stewart.

13 THE CHAIRMAN: Mr. Naylor?

14 MR. NAYLOR: I realize time is getting on and
15 I will try to make this very brief. I was going to refer to the
16 pooling and the functions of Medical Carriers Incorporated, but
17 I think it has been pretty well covered. I think you do
18 probably realize that the main function of Medical Carriers
19 Incorporated would be to operate a pooling arrangement, although
20 the Bill does not say so. I think you needn't be concerned
21 that it will be set up in a way that will exercise undue
22 influence or control on the carriers, because there are quite
23 a few of us interested in seeing that that does not happen.

24 MR. STEWART: Thank you.

25 MR. NAYLOR: Now, about the pooling arrangement,



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that it will be set up in a way that will exercise undue

influence or control on the carriers, because there are quite

a few of us interested in seeing that that does not happen.

MR. NAYLOR: Now, about the pooling arrangement,



1 probably it would be designed in such a way that carriers,
2 such as your own, which has a large proportion of persons in
3 the over-sixty-five, as you have indicated, it appears you have
4 done an excellent job in that respect and you would benefit
5 from a pooling arrangement, rather than contributing. So if
6 these principles were followed up, it would be to your
7 advantage to participate in a pool.

8 MR. STEWART: Thank you.

9 MR. NAYLOR: One other point. On page 7, you
10 speak about discrimination against the self-employed. I just
11 wanted to clarify that in my own mind a bit. In providing
12 insurance for the self-employed, there is the expense factor to
13 be considered. There is a higher expense in selling the plan
14 and in administering it and collecting premiums than where the
15 insurance is provided through groups and I wondered if you feel
16 that it is discriminatory if you do make provisions for these
17 higher expenses in your rates to self-employed persons or
18 individuals? In other words, do you mean if you charge a
19 higher premium to individuals, you are discriminating and to
20 avoid any discrimination you would have to have uniform rates
21 for individuals and groups? Is that what you are suggesting?

22 MR. STEWART: I think the key to our statement
23 here is in the first sentence. We were merely pointing out in
24 the statement that there is a factor here whereby the self-
25 employed have to pay their own and in the next sentence we say:



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MR. STEWART: Thank you.

MR. MAYNOR: One other point. On page 7, you
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wanted to clarify that in my own mind a bit. In providing
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be considered. There is a higher expense in selling the plan
and in administering it than in selling premiums from where the
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MR. STEWART: I think the key to our statement
here is in the first sentence. We were merely pointing out
the statement that there is a factor here whereby the self-
employed have to pay their own and in the next sentence we say



1 "To penalize the self-employed further by
2 discriminatory premium structures based not even
3 on any concept of age or physical condition,
4 but purely on one of being self-employed is
5 extremely unjust."

6 Mr. McCoig, do you have a different rate for
7 group than you do for self-employed? Can I just ask you to
8 make a comment on this?

9 MR. McCOIG: Yes we do, Mr. Chairman.

10 MR. NAYLOR: I think that answers my question
11 then. I just wanted to bring out the point that there are good
12 reasons for charging a higher rate for individuals, that it
13 really is not discriminatory, and I see that you agree with
14 that because of your practice?

15 MR. STEWART: Yes.

16 MR. NAYLOR: That is all I need say on that. One
17 other point about insuring individuals is that you have to have
18 some protection against anti-selection and I wondered what your
19 practice is there. Do you obtain any form of evidence of
20 health from individuals?

21 MR. STEWART: Did you say "anti-selection"?

22 MR. NAYLOR: Yes. That is protection against
23 a person taking the insurance just when they feel they are
24 going to need it and making a claim. So the question is: Do
25 you obtain any evidence of health from individuals?



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Mr. Macdonald, do you have a different rate for
groups than you do for self-employed? Can I just ask you to
make a comment on that?

MR. MACDONALD: Yes we do, Mr. Chairman.

Now I think that answers my question
then. I just wanted to bring out the point that there are
really is not discriminatory, and I see that you agree with
that.

MR. STEWART: Yes.

MR. NATHAN: That is all I need say on that. On
other point about insuring individuals is that you have to pay
some protection against anti-selection and I wondered what your
practice is there. Do you obtain any form of evidence of
health from individuals?

MR. STEWART: Did you say "anti-selection"?

MR. NATHAN: Yes. That is protection against
going to need it and getting a claim. So the question is: Do
you obtain any evidence of health from individuals?



1 MR. STEWART: Yes, we do. We have waiting
2 periods in certain cases and we have opening dates. This, again,
3 varies from county to county. We are getting to the point
4 where we are pretty well accepting people regardless of age or
5 condition.

6 MR. NAYLOR: In an open enrolment period, you
7 would accept them?

8 MR. STEWART: Yes.

9 MR. NAYLOR: Outside open enrolment periods, do
10 you get a health statement?

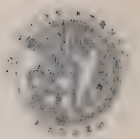
11 MR. STEWART: We always get a health statement.

12 MR. WHITNEY: Why do you get it?

13 MR. STEWART: It is something that we have
14 utilized within recent years, but within the past year or so
15 I think most counties, unless it is a very evident situation --
16 sometimes we will accept a member with an exemption for a
17 certain condition which they say is in effect at the moment.
18 I mean, a man or a woman may join and indicate that there is
19 a certain condition for which they are then receiving medical
20 attention and we would accept the whole family, except this
21 particular condition in this particular individual; so that it
22 does not rule out the whole family.

23 MR. WHITNEY: Is it always a consideration in
24 your underwriting an application?

25 MR. STEWART: It is always a consideration, yes.



1 MR. STEWART: Yes, we do. We have waiting
2 periods in certain cases and we have opening dates. This, again,
3 varies from county to county. We are getting to the point
4 where we are pretty well accepting people regardless of age or
5 condition.
6
7 MR. NAYLOR: In an open enrolment period, would accept them?
8
9 MR. STEWART: Yes.
10
11 MR. NAYLOR: Outside open enrolment periods, do you get a health statement?
12
13 MR. STEWART: We always get a health statement.
14
15 MR. WHITNEY: Why do you get it?
16
17 MR. STEWART: It is something that we have
18 utilized within recent years, but within the past year or so
19 I think most counties, unless it is a very evident situation --
20 sometimes we will accept a member with an exemption for a
21 certain period of time. I mean, a man or a woman may join and indicate that there is
22 a certain condition for which they are then receiving medical
23 attention and we would accept the whole family, except
24 particular condition in this particular individual; so that it
25 does not make any difference.
26
27 MR. WHITNEY: Is it always a consideration in
28 your underwriting an application?
29
30 MR. STEWART: It is always a consideration, yes.



1 MR. NAYLOR: You then could operate under the
2 pooling arrangement quite well because you have some evidence
3 of health that would determine if a particular risk should be
4 put into the pool or not?

5 MR. STEWART: Yes. I think that all our
6 counties on their application forms have a statement which the
7 person must sign, indicating if there is any present condition
8 for which they are receiving medical care. This is about as
9 far as we go.

10 MR. NAYLOR: That is all, thank you.

11 THE CHAIRMAN: Mr. Simon.

12 MR. SIMON: I have just one or two questions
13 with reference to Carriers Incorporated. I notice that you
14 are trying to curtail the functions of Carriers Incorporated.
15 Would you agree that the sole people to decide the premiums
16 should be the Carriers Incorporated, the people that are the
17 carriers, or should there be some public participation in the
18 decision of the amount of premiums that the public is going to
19 pay?

20 MR. STEWART: By "public participation", do you
21 mean government?

22 MR. SIMON: I wonder whether you have studied
23 this section dealing with the setting of premiums in the Act?

24 MR. STEWART: Yes, I think we have.

25 MR. SIMON: On page 7 of the Act, 18(b) it says:



1 MR. NAYLOR: You then could operate under the
2 pooling arrangement and as well because you have some evidence
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22 MR. STUWART: Yes, I think we have.

23 MR. SIMON: On page 7 of the Act, 38(a) it says



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1 "Medical Carriers Incorporated may at any time,
2 but not fewer than sixty days and not more than
3 ninety days before the end of the year, with the
4 consent of the Superintendent, adjust the
5 maximum subscription rate."

6 Then it goes on to spell out that no agreement can be reached
7 unless there is an arbitration board set up, and it says:

8 "(2) If the Superintendent does not within
9 thirty days of the date of application by Medical
10 Carriers Incorporated consent to the adjustment
11 of the maximum subscription rate, the matter shall
12 be referred for decision to a board of three
13 arbitrators, one to be name by the members
14 licensed to undertake the business of accident
15 and sickness insurance under The Insurance Act,
16 one to be name by all other members, and one
17 to be named by a judge of the Supreme Court upon
18 the application of the other two arbitrators."

19 On the board there would be one public representative -- that
20 would be the chairman -- and the other two would be from the
21 carriers who sell the insurance. The public does not come into
22 the picture. What are your views as to where the public is
23 going to be, those who have to pay the bills, after all is said
24 and done?

25 MR. STEWART: We tend to look on government as



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1 representative of the public. I think they would be pretty
2 actively involved, Even though it were presumed that the
3 carriers, through Medical Carriers Incorporated, were officially
4 setting the rate, I think that the interests of the public
5 would be handled largely by government. I do not know.

6 MR. SIMON: Wouldn't you say the dice would be
7 loaded there two to one?

8 THE CHAIRMAN: That is a leading question, Mr.
9 Simon. I think their opinion has been expressed when they
10 state in their brief here that they would prefer to have this
11 done by the Superintendent of Insurance.

12 MR. STEWART: I would like to say, Mr. Chairman,
13 Mr. Simon intimated that we were proposing to limit the function
14 of Medical Carriers. This I do not think is inherent in our
15 brief. We are merely stating that as far as we can determine,
16 that is the function of Medical Carriers. So, we are not in
17 any way limiting or attempting to. This is as far as we can
18 see, or as far as we have been told, and if that is the only
19 function, we feel that it can be done in a different way.

20 MR. SIMON: On page 8, paragraph 17, you refer
21 to the percentage of your members 65 years and over being 23%,
22 against an average of 13, is it? In providing insurance on an
23 equitable basis for those people, how do you do it? Do you
24 make a better deal with the insurance companies or do you sub-
25 sidize these?



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1 MR. STEWART: It has not been our experience
2 that they are a more expensive class. Is this what you mean?

3 MR. SIMON: Yes.

4 MR. STEWART: The over 65's?

5 MR. SIMON: Yes.

6 MR. STEWART: We have been told, time and time
7 again, that it has not been our experience that they are the
8 big risk in our groups. Would you say that is correct, Mr.

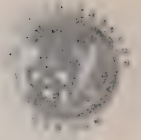
9 McCoig

10 MR. McCOIG: Yes, I believe it is, Mr. Chairman.
11 At the end of December, the 31st, which is the end of my fiscal
12 year, we are going into machine operation and when we do, then
13 we can have complete statistics on several thousand people,
14 including the city people and urban, because they are separate
15 and will be for the year 1963

16 MR. STEWART: Again, we have variations in our
17 counties.

18 I would like to introduce, Mr. Chairman, Dr.
19 Forshaw from Guelph, who has just come in. He is Vice-President
20 of the Federation. I believe you have a variation in relation
21 to the over 65's, is that correct, in your premium structure?

22 DR. FORSHAW: Yes. For a number of years we
23 had a uniform premium. I think perhaps it is more than fair
24 to say that the people who joined medical co-operatives
25 originally, twenty years ago, were the type of people who took



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1 good care of themselves. We find now that when we have an
2 open period, particularly if we do considerable advertising,
3 that we are perhaps bringing in a poorer group of risks. It
4 is true that certain of our older members do have rather large
5 bills at times, but others of them turn out to be very good
6 risks. However, in our particular county, we state that our
7 coverage is available to one hundred per cent of our people and,
8 accordingly, those people who have not availed themselves of
9 the coverage and are over 65, or those who have had our minimum
10 coverage whose case history we know makes them bad risks, we
11 have an extra premium for them, Mr. Simon. We have only had
12 this since January 1. We will be determining whether this is
13 so. We do not mind subsidizing, to some extent, but we do not
14 want to accept all of the bad ones without building in some-
5 15 thing in our premium structure, and we still think it is
16 equitable because we do not mind asking our better risks, when
17 they are better risks, to do some subsidization but we do not
18 want it to be as much as to make it non-competitive.

19 MR. STEWART: We have one or two counties that
20 pioneered in this sort of thing. On the basis of their record,
21 we will be able to determine what we should recommend to the
22 rest of our groups.

23 MR. SIMON: Might I suggest that if these figures
24 are available, that the Commission gets them, if possible.

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1 MR. SIMON: The figures.

2 MR. STEWART: Of the older age group?

3 MR. SIMON: Yes.

4 MR. STEWART: Yes. I am sure that we can see
5 that they will be available.

6 MR. MAJOR: If we are going to get those figures,
7 can we also get the underwriting feature that is applicable to
8 that on an individual basis because I gather that these people
9 are individually underwritten?

10 MR. STEWART: Not individually -- as a group.
11 It probably should be a lesser coverage applied for a greater
12 coverage.

13 DR. FORSHAW: This is correct. That is, we
14 went on the general premise that those persons who had always
15 carried the best coverage we had would be entitled to continue
16 to carry the best coverage -- namely, comprehensive -- without
17 restriction. We have, to my certain knowledge, no restricted
18 contracts. We have never dropped a member on account of health
19 status. That is, we did not allow them to come from just a
20 major medical plan, which costs them \$12.00 a year, all the way
21 to a comprehensive if, in fact, we felt that they were, say,
22 diabetic or had other conditions. That is, we said "You can
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2 the fact that a very high percentage of our people are taking
3 the best contract available.

4 THE CHAIRMAN: When we receive the statistics,
5 if there is additional information that they can provide, you
6 can come back?

7 MR. STEWART: Most of our counties at the
8 present time do not have special rates for those over 65 and
9 we are probing a bit into this field to see how it will do.

10 THE CHAIRMAN: When you are providing us with
11 the statistics, if you will keep in mind that the more informa-
12 tion you can give us relative to this, the more helpful it will
13 be.

14 MR. STEWART: Fine.

15 DR. BUTT: Well, I would like to congratulate
16 Mr. Stewart and his colleagues on their brief and presentation.
17 I happened to pick up a few more little brochures on the details
18 of how you present it at the local level.

19 I was interested in one thing. I think this is
20 from Bruce Co-Operatives, and then it is down here in Essex,
21 and your benefits are paid from the Essex County of 90% of the
22 O.M.A. Schedule. Then you go down to the other one, and this
23 little provision isn't included.

24 This has to do with surgical operations,
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1 MR. STEWART: I wasn't aware that Essex had
2 negotiated this deal, or I think this just points out again
3 the viability of our local co-operatives, and this is the thing
4 of which we are particularly proud, though it causes us a lot
5 of trouble at times.

6 It would be much simpler to say this is it, take
7 it or leave it, but it's essentially a service organization.
8 We've found in the hospital field that it's very useful to
9 have local contacts.

10 DR. BUTT: Do you know any reason why there
11 would be a variation in this particular point?

12 MR. STEWART: Well, this gets back to this 90%
13 deal, and it's been a long drawn out affair.

14 We had recommended to our Counties at one time
15 that they ought to endeavour to negotiate with the doctors
16 with whom they are doing business that they would accept this
17 90%, but we've never been able to achieve this. Now, as I
18 understand it, Essex have said we are only going to pay 90%.

19 DR. BUTT: In your recommendation number five
20 you refer to it as bursaries, and this is usually considered
21 in the undergraduate field. In other words, there are certain
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1 the normal benefits would then be presented, shall we say, to
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3 MR. STEWART: The resident physician do you
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5 DR. BUTT: The resident physician or resident
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7 these people should be helped in their medical training?

8 MR. STEWART: A sort of supplement you mean?

9 DR. BUTT: Well, it's not a supplement. It's
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11 benefits for services rendered, and it might go to him. It's
12 just a matter of where you want to allocate these funds.

13 At the moment it's done where insurance is
14 available, it apparently goes to a pooling arrangement in the
15 hospital, or university arrangement.

16 MR. STEWART: No, our concept of this was an
17 undergraduate program. Now, I can see a great field of develop-
18 ment in what you propose, or suggest.

19 DR. BUTT: Well, I wasn't suggesting anything.
20 I was just clarifying.

21 MR. STEWART: Well, in the field of encourage-
22 ment for general practitioners, and this sort of thing,
23 certainly as a rural organization we are very concerned about
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25 DR. BUTT: I think this is all, and I congratulate



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DR. BUTT: I think this is all, and I congratulate



1 you on extending yourself all the way up to Manitoulin Island
2 and other places.

3 THE CHAIRMAN: On the counties which include
4 payment for chiropractic services, is this part of the standard
5 plan, or is this the major plan?

6 MR. STEWART: No, this is a separate plan. This
7 has been negotiated between us as a Federation and the
8 Chiropractic Association in detail, but the actual operation
9 is negotiated between the county group and the chiropractic
10 Association, but it is a separate contract, and not part of
11 our standard contract.

12 MR. CASWELL: This, I take it, would mean a
13 separate charge?

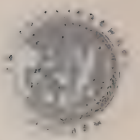
14 MR. STEWART: A separate contract, yes.

15 DR. BUTT: Is this true of your proposed
16 negotiation with the optometric association?

17 MR. STEWART: Yes.

18 DR. BUTT: I notice also you almost, and I say
19 almost have a deductible, or a co-insurance factor of about
20 almost 50%. Is that correct, with regards to glasses and so
21 on? It says examination refraction, and when I work it out
22 here it's \$5.00 per \$10.00, which may be reasonable, but this
23 is what it appears to be?

24 MR. STEWART: Yes, this is still under negotia-
25 tion, and it hasn't been settled in any way. We've gone a great



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24 is what it appears to be?
25 MR. STEWART: Yes, this is still under negotia-
26 tion, and it hasn't been settled in any way. We've gone a great



1 distance in our negotiation with them, but it isn't in effect
2 in any place at the moment.

3 MR. MULROONEY: Mr. Stewart, I have been
4 wondering whether there's any way that farm people could obtain
5 the advantage of group rates.

6 There are a considerable number of organizations
7 of farm people. Would it not be possible for the Co-Operative
8 Medical Services Federation to develop liaison with these
9 organizations, and to enrol them on a group basis possibly
10 with the co-operation of the Co-Operative Union and other
11 organizations of this kind?

12 MR. STEWART: We do have many farmers who are
13 in our organization on a group basis through our co-operatives.

14 In my county, for instance, the Perth District
15 Services employees are on a group basis, and you are speaking
16 more of the farmers themselves?

17 MR. MULROONEY: I am speaking of the variety
18 of farm organizations, the marketing boards, the wheat growers,
19 all of these people are organized, and it should be possible,
20 it seems to me, to develop a service through the existing
21 organization on a group basis.

22 MR. STEWART: One of the difficulties we've run
23 into in trying to think of this, and we've given it a great
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1 We have many of these people as members.

2 MR. MULROONEY: Nevertheless, among your
3 organizations the people of any organization could be serviced
4 by the people within the county, and you could develop a
5 uniform contract, shall we say, that could be underwritten by
6 the co-operatives within the county.

7 I suggest that this could be possible.

8 This leads to another question that has been
9 thought about a little anyway, and obviously I can't speak for
10 other carriers, but I wonder whether the Co-Operative Medical
11 Services Federation would wish this Enquiry Committee to con-
12 sider requesting carriers to leave enrolment of farm people to
13 the Co-Operative?

14 In other words, leave this field to your
15 organization. I'm suggesting that this is a suggestion which
16 you might put forth to this Committee.

17 MR. STEWART: This is something which I think is
18 a little foreign to our thinking in this field, and again,
19 reverts back to the independence and individuality of the farm
20 people.

21 I feel I would want to compete for further
22 interest, and certainly we have never considered requesting that
23 this field be left.

24 MR. MULROONEY: I am merely suggesting that in
25 operation obviously neither you nor I, nor anybody else can



We have many of these people as members.

MR. MULROONEY: Nevertheless, among your

by the people within the county, and you could develop a
uniform contract, shall we say, that could be underwritten by
the co-operatives within the county.

I suggest that this could be possible.

This leads to another question that has been

thought about a little anyway, and obviously I can't speak for
Services Federation would wish this Endury Committee to con-
sider the Co-Operative?

In other words, leave this field to your
organization. I'm suggesting that this is a suggestion which
you might put forth to this Committee.

MR. STEWART: This is something which I think I
a little foreign to our thinking in this field, and again

I feel I would want to compete for further
this field be left.

MR. MULROONEY: I am merely suggesting that in



1 control the individual.

2 MR. STEWART: No.

3 MR. MULROONEY: It is simply that carriers
4 would not attempt to enrol farm people. A farmer who wishes
5 to enrol in P.S.I., Cumba, or anything else, is perfectly free
6 to do so, but the field would be left to the county co-operatives.

7 This is the kind of approach that I would like
8 you to consider.

9 MR. STEWART: It's something that we could give
10 some consideration to, but, as I say, we haven't done so yet.

11 MR. WHITNEY: Mr. Chairman, first I would just
12 like to make an observation that I've enjoyed the brief very
13 much that you gentlemen sent in, and this sort of brief, you
14 know, is a pretty basic type of brief for our thinking, so that
15 you probably have been subjected to a pretty rigorous time
16 here this morning, because this field is very much the field
17 that the standard contract envisaged in the Act and so on is
18 going to be in, and the nature of the services, and so on, are
19 so much similar.

20 I want you to also feel that some of these
21 questions that you were given have been some personal expressions
22 of opinion from Members of the Enquiry, or it might be implied.
23 These are their opinions, and we still have quite a bit of work
24 to do before we down to assisting the Chairman in making his
25 final recommendations, and I've taken clear notice of what you



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final recommendations, and I've taken clear notice of what you



1 said about Medical Carriers Incorporated, the fact that there
2 seems to be some spelling out to be done yet. I personally
3 feel the same way, and also on pooling there's a great deal of
4 thinking yet to be done on that.

5 The only question I have is do you have any
6 specimen annual reports from, say two or three of your autonomous
7 organizations, that you might supply the Enquiry?

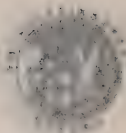
8 I'm thinking of probably one that started in the
9 last five years, and maybe one that has been going for ten
10 year, and one that has been going for fifteen years. A financial
11 report, or any sort of report where you list your claims, and
12 what happens under the various type of illness, and so on.
13 This might be of use to us.

14 MR. STEWART: Yes, we can certainly provide this
15 for you, because it's made available to every member of our
16 Co-Operative following the end of our fiscal year, and prior
17 to the annual meeting. So that we could see that you would get
18 a variety of those.

19 I wouldn't say any within the last five years,
20 because I don't think there have been any organized within the
21 last ten years. I think they have been going pretty well as a
22 group since about 1950.

23 How many copies of this would you want? Some-
24 thing for the record?

25 MR. WHITNEY: Well, if you are going to copy them,



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1 you might, say, make up 15, or 20 copies, and send them in to
2 our Secretary, and whoever on our Enquiry wishes to see what the
3 financial operation of the co-operative looks like could get
4 them.

5 MR. MAJOR: How many men, women and children do
6 the 31 organizations have under coverage now?

7 MR. STEWART: I would guess it's around 300,000.

8 THE CHAIRMAN: Gentlemen, I think that the
9 questions indicate the interest there is in your brief. Do you
10 have any further comments?

11 MR. STEWART: Only to thank you very much sir.
12 I have enjoyed it, and we hope that we've added a little to
13 your knowledge of how we operate, and certainly we would be
14 pleased to meet with you again, or provide any supplementary
15 information that you feel, when you are considering these
16 matters, that you feel we might provide, and we'll certainly
17 see that you get copies of the contracts and financial
18 statements.

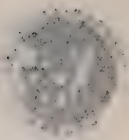
19 THE CHAIRMAN: Is the delegation here from the
20 Ontario Hospital Association?

21
22 SUBMISSION OF

23 THE ONTARIO HOSPITAL ASSOCIATION

24 APPEARANCES:

25 Mr. Proctor Dick
Mr. Alan Hay
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1 THE CHAIRMAN: Ladies and gentlemen: I'm sorry
2 that it's been necessary to hold you up beyond the time of your
3 appointment. I think the reason has been obvious to you, and
4 we do not wish to curtail our questioning in this.

5 We are here for the purpose of procuring all
6 the information we can. We did try to estimate the time that
7 would be required. We didn't do so well in estimating the
8 time for the first group this morning.

9 I would like to read to you the instructions
10 that are given to all members of the delegations appearing
11 before us.

12 Members of the Enquiry have received and studied
13 the brief you submitted. In accordance with the guide for
14 participation in hearings that was mailed to you, it will not
15 be necessary for you to read your brief, but you do have an
16 opportunity to emphasize or enlarge upon its conclusions or
17 recommendations.

18 Members of the Enquiry may ask you questions on
19 the statements or recommendations submitted in your brief, but
20 you are not to be subjected to examination or cross-examination
21 by other persons.

22 It is not our intention to debate your sugges-
23 tions or recommendations, nor to state the views of this Enquiry
24 on them. Consequently, any opinions expressed in questions
25 asked or statements made by members of the Enquiry are intended



THE CHAIRMAN: Ladies and gentlemen: I'm sorry
that I'm not able to attend this morning's
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1 for clarification only.

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3 act as your spokesman. However, if the spokesman feels that
4 another member is better qualified to answer a specific question
5 from a member of the Enquiry, the spokesman may receive the
6 Chair's permission to request the other member to answer.

7 Will you please identify your spokesman, and
8 then proceed.

9 The members of the press have requested a copy
10 of your brief, and if you have copies with you, perhaps you
11 will hand them to the members of the press at the conclusion of
12 your submission.

13 Now, if we're not able to conclude the dis-
14 cussion by about twelve-thirty, are you prepared to come back
15 after lunch, say at two o'clock?

16 MR. DICK: Yes, I would say so Mr. Chairman.

17 THE CHAIRMAN: Who will then be your spokesman?

18 MR. DICK: Mr. Chairman, if I may address you
19 and the members of the Enquiry, I will introduce myself. I am
20 the President of the Ontario Hospital Association, and a Member
21 of the Board of the Public General Hospital at Chatham. My
22 name is Proctor Dick.

23 On my immediate left is Mr. Alan Hay, President-
24 Elect of the Ontario Hospital Association, and a Member of the
25 Board of the Brockville General Hospital; on his immediate left



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1 is Mrs. Charles McLean, Past Chairman of the Board of the
2 Women's College Hospital, Toronto, and Chairman of our
3 Legislation Committee of the Ontario Hospital Association, and
4 also a Past President of the Association; Mr. Holland was not
5 able to be here, or not able to get in this morning,
6 apparently. On my immediate right is Mr. S. W. Martin,
7 Executive Secretary-Treasurer of the Ontario Hospital Associa-
8 tion; and on his immediate right is Mr. Max B. Wallace,
9 Superintendent of the Toronto Western Hospital, and Past
10 President of the Ontario Hospital Association.

11 May I, sir, congratulate you on your appointment
12 to this very responsible job of getting out all the information
13 that's necessary in order to formulate the policy of this
14 very important Bill.

15 We here are somewhat on the defensive role,
16 possibly, but we have stated some of our opinions and con-
17 clusions in our brief, and with your permission, sir I would
18 like to read the summarization of these conclusions, and our
19 recommendations, which may put them in better perspective than
20 for me extemporaneously to relate them to you.

21 The Ontario Hospital Association is of the
22 opinion:

23 (a) That the implementation of Bill 163 should receive
24 very careful study due to the possibility that funds necessary
25 for existing health services may be affected adversely by the



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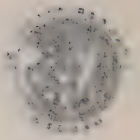
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- 1 financial demands on government of an additional health
2 programme at this time. You may wish to refer to paragraph 10.
3 (b) That the inclusion of laboratory, radiological,
4 and other diagnostic services now provided by hospitals as
5 benefits under the Hospital Services Commission Act is sound
6 and the Association supports their exception from Bill 163.
7 The reference there is paragraph 14.
8 (c) That hospital services provided to other than
9 inpatients are an established function and will continue to be
10 utilized by the public. (Para. 18)
11 (d) That hospitals should be paid the costs of
12 providing services to other than inpatients. That is covered
13 in paragraph 21.
14 (e) That organized outpatient departments, with the
15 co-operation of medical staffs, may be established in hospitals
16 other than teaching hospitals. This is referred to in para-
17 graph 18.
18 (f) That traditional and proven hospital/physician
19 relationships should continue to prevail, and that these
20 arrangements be made at the individual hospital level. Para-
21 graph 20 covers this one.
22 (g) That the implementation of an educational
23 programme designed to acquaint the public with the importance
24 of patients voluntarily associating themselves with teaching
25 programmes is a sound approach to meeting the continuing needs



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22 (g) That the implementation of an educational
23 programme for hospital staffs, and the establishment of a
24 of patient education programme, are essential to the
25 programme as a whole.



1 of medical education. This is covered in paragraph 23.

2 (h) That adequate medical services for patients
3 in convalescent and chronic care hospitals is essential and
4 that the reimbursement for such services be interpreted as a
5 benefit under Bill 163. The reference here is paragraph 24.

6 (i) That the definition of "benefit" in section 1(a)
7 of Bill 163 be clarified. Paragraph 25 of the brief covers
8 this one.

9 (j) That medical practitioners classified as intern
10 and/or resident staff and receiving hospital stipends therefor
11 should not have the right to bill, and collect from, patients
12 and that "physician", as defined in section 1(1) of Bill 163,
13 be rephrased to preclude such an interpretation. This is in
14 paragraph 26.

15 (k) That the implications for laboratories in general
16 hospitals resulting from the exception in Schedule A of
17 "services of government or commercial laboratories" should be
18 carefully studied. This one is paragraph 28.

19 That is our summarization, Mr. Chairman, and I
20 feel that the brief has been very well thought out by those
21 who prepared it, and possibly there is something that is not
22 covered that you would like to ask about.

23 We would be very happy to undertake to clarify,
24 if we can, the items that might be in question.

25 THE CHAIRMAN: Some of our members do have



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THE CHAIRMAN: Some of our members do have



1 questions. Miss McArthur?

2 MISS McARTHUR: Thank you Mr. Chairman. In
3 the summary, paragraph (a), I was interested to know whether
4 the word "implementation" is what you mean, rather than a
5 questioning of the Bill itself?

6 In other words, are you concerned that the
7 Bill has problems within it, or are you more concerned that it
8 be implemented in relation to foreseeable costs, and then
9 cautiously from there on in?

10 MR. DICK: Well, possibly I couldn't answer that
11 for you, Miss McArthur, but maybe Mr. Martin could clarify
12 what was intended in that word "implementation".

13 MR. MARTIN: I think that the interpretation
14 that Miss McArthur has put on the recommendation, or observa-
15 tion, is what we had in mind.

16 We are mindful that there are problems in rela-
17 tion to already established programs, and taxing powers, and
18 moneys that are available, and it would be the continuing
19 program that would be of concern.

20 MISS McARTHUR: In paragraph (e), in relation
21 to out-patient departments, I was wondering why more out-
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24 You say "may be established", on page 7, item
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24 You say "may be established", on page 7, item
25 18, and I wondered if you had any reason why hospitals haven't



1 developed this kind of department?

2 MR. DICK: Well, Mr. Chairman, to Miss McArthur,
3 my understanding is that out-patient departments have been
4 organized where medical staffs are available, and the set-up,
5 or the physical facilities are available in a hospital to
6 properly handle out-patient services, and that there are
7 finances available to handle the out-patient services.

8 Some of these out-patient services relate them-
9 selves to medical care, and they also involve voluntary services
10 in some cases, with medical staffs at the present time.

11 As I understand it, in that way, they have been
12 in the past most related to teaching hospitals.

13 Am I right in that Mr. Wallace?

14 MISS McARTHUR: I can understand why it would
15 happen in teaching hospitals, but it's a little switch in the
16 philosophy of some groups who have expressed the concern that
17 this would no longer continue under such a Bill, and this brief
18 seems to indicate that it may be extended.

19 MR. WALLACE: I believe, Mr. Chairman and Miss
20 McArthur, that because the image of the hospital now is somewhat
21 different to what it was ten, fifteen, or twenty years ago,
22 and the fact, or the suggestion that out-patients -- maybe out-
23 patient departments may be organized where they are not
24 presently organized, is because people now in the main, when
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MR. WALLAGE: I believe, Mr. Chairman and Miss McArthur, that because the image of the hospital now is somewhat different to what it was ten, fifteen, or twenty years ago, and the fact, or the suggestion that out-patients -- maybe out-patient departments may be organized where they are not presently organized, is because people now in the main, when they are injured --- When I was younger, and we were injured,



1 it was "Rush him to the doctor's office". Now when people are
2 injured the picture is "Rush him to the hospital", and I think
3 that that's why we would feel that hospitals who don't have
4 out-patient departments might conceivably be permitted to
5 organize them, because the public might demand that care.

6 MISS McARTHUR: You see it as a public demand,
7 rather than the public thinking that now that there is a Bill
8 in giving service they no longer require this kind of thing?

9 MR. WALLACE: Well, I still feel that the picture
10 that people nowadays have of a hospital is that it's there all
11 the time; it's certainly to be open all the time; and it's
12 certain to have some sort of medical, paramedical coverage.
13 Therefore I feel that the public is, little by little by little
14 getting into the habit of rushing to the hospital, and there-
15 fore I think that these hospitals who don't have these may wish
16 to organize them, and the doctors may wish to take care of their
17 patients in the hospital.

18 A doctor now, when he is called, on occasions
19 says "Meet me at the hospital".

20 MISS McARTHUR: And in paragraph (h), I have a
21 question Mr. Chairman. Do you feel that Bill 163 would not
22 provide medical services to convalescent and chronic care
23 hospitals, or are you expressing your concern that they are not
24 available.

25 MR. DICK: Mr. Chairman, I would like to have



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19 says "Meet me at the hospital".
20 MISS McARTHUR: And in paragraph (b), I have a
21 question Mr. Chairman. Do you feel that Bill 163 would not
22 provide medical services to convalescent and chronic care
23 hospitals, or are you expressing your concern that they are not
24 available.
25 MR. DICK: Mr. Chairman, I would like to have



1 Mr. Martin answer that, if I may.

2 MR. MARTIN: I think what we have really said
3 here is that we at the moment are interpreting that they will
4 be, and we hope that they are.

5 MISS McARTHUR: You are emphasizing the way you
6 wish to secure this?

7 MR. MARTIN: Yes, to make sure that they are.

8 MISS McARTHUR: I think I'm maybe being Mr.
9 Whitney, Mr. Chairman. I'm wondering whether the group have
10 another definition of benefit, and maybe I should leave it to
11 Mr. Whitney.

12 In paragraph (j) there are many questions I
13 have there, but I'll leave them to Dr. Galloway or Dr. Butt,
14 or the other doctors.

15 I'll leave my other questions until I find out
16 if they are answered.

17 THE CHAIRMAN: Mr. Dick, it has been suggested to
18 me that it would be desirable for you to define what you mean
19 by your interpretation of out-patients, that there are out-
20 patients who attend clinics, and who are recognized as public,
21 or visiting patients, and there are out-patients who utilize
22 the diagnostic, or some other department of the hospital, and
23 pay for the service as private out-patients.

24 Could you define this?

25 MR. DICK: Mr. Chairman, probably if we refer to



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10 Mr. Whitney.

11 In paragraph (1) there are many questions I

12 have there, but I'll leave them to Dr. Galloway or Dr. Butts,

13 or the other doctors.

14 I'll leave any other questions until I find out

15 if they are answered.

16 THE CHAIRMAN: Mr. Dick, it has been suggested

17 me that it would be desirable for you to define what you mean

18 by your interpretation of out-patients, that there are out-

19 patients who attend clinics, and who are recognized as public,

20 or visiting patients, and there are out-patients who will

21 pay for the service as private out-patients.

22 Could you define this?

23 MR. DICK: Mr. Chairman, probably if we refer to



1 paragraph 16, on page 6, in the Hospital Services:

2 "Every hospital provides a form of out-patient
3 service. In the majority of hospitals, this will
4 consist of emergency care and such diagnostic
5 procedures as laboratory tests and x-rays for
6 ambulatory patients, i.e., those who are able
7 to come to the hospital but do not require
8 admission as an in-patient for the service
9 required. In 22 hospitals of this province
10 (including all the teaching institutions listed
11 in Appendix A) there are, in addition, what are
12 termed 'organized out-patient departments'
13 these departments provide regularly scheduled
14 general clinics as well as consultative services,
15 and are supervised by members of the hospitals'
16 medical staffs."

17 THE CHAIRMAN: Is this satisfactory to everyone?

18 DR. GALLOWAY: I might ask this question, if I
19 may speak to it, Mr. Chairman. In this question coming up you
20 are obviously speaking of out-patient departments which, up to
21 this moment, have been for the public, or indigent patient.

22 I am sure we will be speaking, as we go along,
23 of out-patient clinics for private out-patients, and it would
24 help, as you go along, if you would describe them as public
25 out-patient or private out-patient.



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of out-patient clinics for private out-patients, and it would help, as you go along, if you would describe them as public



1 MR. DICK: May I ask Mr. Martin to expand on
2 that a little bit.

3 MR. MARTIN: We agree that this can be a very
4 confusing point, but we were trying to say that, in essence,
5 there is an organized program in co-operation with the medical
6 staffs of those hospitals in the 22 that are set down here,
7 and they are largely teaching centres, or in the urban areas.
8 These are what we call organized out-patient departments, but
9 there are out-patient departments in nearly every other hospital,
10 or there are out-patient facilities, or services, that are
11 provided.

12 DR. GALLOWAY: It was just the way we should use
13 the terms when we are speaking of one particular group or the
14 other.

15 THE CHAIRMAN: You prefer to delegate some of
16 these questions, so it won't be necessary for you to ask the
17 Chair's permission.

18 MR. CASWELL: Mr. Dick, all through your brief
19 it is apparent that the Ontario Hospital Association is greatly
20 concerned about the implementation of the Bill, because of the
21 mechanics of the Bill.

22 Do you agree that as far as the government is
23 concerned, and therefore the public money, that the indigents
24 are going to be covered, and they are already being covered
25 through public welfare, and there's going to be, or planned to



1 be some assistance given to the low income group. So this

2 I assume that the amount of concern you have,

3 and you have given some study to this thought -- has this

4 study suggested to you that we will not be able to economically

5 put this medical services plan into effect without, shall I say,

6 disturbing hospital money today?

7 I think that's what you must be concerned about

8 if there's not enough money to go around?

9 MR. DICK: Well, Mr. Chairman and Mr. Caswell,

10 the Hospital Association are most concerned about the rising

11 costs in our program, and are putting forth every effort that

12 we know of to facilitate, or to help hospitals cope with this

13 problem through institutes of all sorts that cause people to be

14 more qualified in their respective areas of operation.

15 This is the only way that we know of that we

16 can create efficiencies, and the people are more capable of

17 doing the work that they are doing, and more capable of organi-

18 zing the work, so that they can accomplish more in the same

19 period of time.

20 We have had pilot projects of one kind or another

21 where consultants have been brought into areas to survey

22 housekeeping as an example, to polish off the operation, or to

23 arrange it in such a way that the cost of doing it is minimized



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25 arrange it in such a way that the cost of doing it is minimized



1 and in the same area, and in our own hospital, which was one
2 of the pilot projects, the nursing operation was also surveyed,
3 and we believe that survey is just in the process of being
4 completed now, or made available in report form. We feel, or
5 felt, that the nursing staff at that particular time, and the
6 Directors of Nursing asked that this be done, because of the
7 results of the housekeeping ---

8 Now, this concern, I think everyone in the
9 hospital field, that they realize that in many areas many people
10 weren't properly remunerated for the services rendered in the
11 past, and there was no other way to operate than the way they
12 did operate, but as soon as the Hospital Services Commission
13 came into existence, the pressure came immediately on the
14 Managers of the hospitals, that these inequities be adjusted.
15 Progressively they have been, but in some areas they are greater
16 than in others, and we are just concerned about this matter,
17 that it can get to the point where it looks like a well that's
18 completely full, and ready to pump, and therefore we want to
19 safeguard that from our angle.

20 But we also wish to make the Committee of
21 Enquiry aware of the fact that there is this factor of cost
22 that should be considered, and which should be kept in mind all
23 the time, because once these matters are instituted, they then
24 relate themselves in a different way to the person who is
25 receiving the benefit, and in many cases the cost of providing



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1 the services pyramids.
2 MR. CASWELL: Perhaps it's true these increasing
3 costs are going on, but we must agree that the introduction of
4 the Ontario Hospital Services has been a great thing for our
5 people, and the same thing with the introduction of medical
6 services. It's going to cost money. We know that, but this
7 is something that must be passed on to all our people, and I
8 fail to see how by deleting this, and not going on with our
9 program, the hospitals would hope to get any more money.

10 So that I don't think it's going to affect your
11 program from that direction.

12 MR. DICK: I'm quite sure, sir, that it was
13 not with the intention of inferring that this would reflect on
14 the hospitals in the sense that it would take anything away from
15 the hospitals.

16 MR. CASWELL: You also are speaking in respect
17 to interns, and staff doctors employed by the hospital, and
18 giving service to the patient, and recommending that their
19 services should be paid for if medical services comes into
20 effect, but that they should not be paid directly, and this
21 money should be paid to the hospitals, and at the same time you
22 are suggesting that the hospitals should have something to say
23 about setting the rates for the medical services provided in
24 hospitals.

25 Am I right?



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MR. GARDNER: Perhaps this time these interesting costs are going on, but we must agree that the introduction of the Ontario Hospital Services has been a great thing for our people, and the same thing with the introduction of medical services. It's going to cost money. We know that, but this is something that must be passed on to all our people, and I fail to see how by deleting this, and not going on with our program, the hospitals would hope to get any more money.

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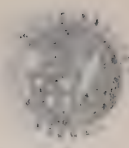
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Am I right?



1 MR. DICK: Possibly if we refer to paragraph 26,
2 which is on page 14, Mr. Chairman. If I may read that:

3 "This may be an appropriate time as well to
4 comment on the definition of 'physician' according
5 to section 1(1) of the Bill, and its implications
6 insofar as hospitals are concerned. Our inter-
7 pretation would be that this definition could
8 embrace the intern, assistant resident, resident,
9 and chief resident staff. At the present time,
10 none of this group bills patients for services
11 rendered; each receives a stipend that forms part
12 of the hospital's operating budget. Patients
13 admitted to teaching areas are under the care of
14 the active staff and the billing of patients will
15 be done by this staff in accordance with the
16 local arrangements that might apply. While the
17 intern and resident staff provide a degree of
18 medical service, under supervision, as part of
19 their educational experience, it would be our
20 concern that Bill 163 as presently drawn could
21 conceivably give interns and residents a right
22 to bill, and collect from, patients. The
23 Ontario Hospital Association hereby records its
24 official position that medical practitioners
25 classified as intern and resident staff and



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1 "receiving hospital stipends therefor should not
2 have such a right and that Bill 163 should be
3 clarified accordingly."

4 I interpret that to mean, sir, that there would
5 be no charge by the hospital against Bill 163 where medical
6 services were rendered by the interns.

7 Do you confirm that, Mr. Martin, that that was
8 the intent?

9 MR. MARTIN: I think the intent, the present
10 method of operation has been stated. The medical services
11 certainly will be billed for, but we did say earlier, and you
12 have to relate the section in which we said that the traditional
13 improvement of the hospital-physician relationship should
14 prevail and this should be left to be worked out at the local
15 level. What we are saying here is there are two parts to the
16 question, as I see it. The first one is that the arrangements
17 for billing should be left as the arrangement that can be made
18 at the local hospital level, as between the hospital and their
19 medical staff, whatever is involved in it. Secondly, in
20 relation to interns, it was just a point that comes up in
21 connection with the Bill. We realize that the interns who are
22 registered on the educational registry of the College are not
23 permitted to bill for their services, but there is an area, a
24 grey area in which residents or different types may have a
25 different type of registration and under the existing law we are



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1 able to bill for their services and we prefer to see it
2 carried out, if it is to be a universal medical care program,
3 carried out under the arrangements as they exist at the present
4 time, as between doctors at the local hospital level.

5 MR. CASWELL: At the present time, a resident
6 doctor does not send the patient a bill?

7 MR. MARTIN: That is correct.

8 MR. CASWELL: But you are suggesting that under
9 this medical services plan that he would be submitting a bill
10 or that the hospital would be?

11 MR. MARTIN: No.

12 THE CHAIRMAN: Mr. Caswell, Dr. Galloway has
13 asked to ask a question relative to this question and then we
14 will return the questioning to you.

15 DR. GALLOWAY: I think it might be of some value
16 to clarify what I think the Hospital Association are trying
17 to bring forward, also to ask another question in this regard.
18 At the present time, there is the intern staff in training.
19 The person who is responsible for all the treatment that is
20 carried on is a member of the medical, surgical or obstetrical
21 staff. The interns who are doing some of this work, or
22 assisting in the treatment, are doing so under his supervision.
23 The man who is responsible renders the bill in that particular
24 situation. The intern staff, therefore, renders no account and
25 are prohibited under the Educational Act from doing so. There



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1 are two points, rather than accept your statement as it is.
2 At the present time, as all staff members are appointed, so
3 are the intern staff appointed by the Board of Directors of
4 the hospital and each hospital has its own set of by-laws and
5 each set of by-laws can surely contain a statement that one
6 of the conditions of employment for an intern is that he shall
7 neither accept payment nor render an account, and this would
8 handle this situation where there are an intern staff throughout
9 this province. However, there are an increasing number of
10 hospitals and there are an increasing number of those hospitals
11 who are not approved by the Canadian Medical Association for
12 the training of interns, and as a result these hospitals cannot
13 find employees who can assist the physicians there in emergency
14 or the routine care of patients by acting as residents. There
15 will undoubtedly be, because of this Act, a considerable amount
16 of money available to physicians who are dealing with hospital
17 services and these small hospitals, under the Ontario Hospital
18 Services Act, cannot find the money to employ such a person.
19 This Bill 163, as I can see it, might well make it possible
20 for a hospital to have on staff, in some capacity, an individual,
21 registered under the Medical Act, who would see such emergency
22 patients and deal with them in the hospital, or as out-patients,
23 as the case may be, to whom this would be a service he could
24 render to the hospital and at the same time be associated with
25 the hospital under their by-laws. I wonder if you can see any



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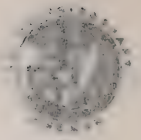


1 objections to this form of procedure, as this can answer the
2 problem of the small hospital?

3 MR. DICK: I possibly couldn't see as far into
4 that as some of those who have been working in hospitals and I
5 would like to ask Mr. Wallace for his comments in this regard.

6 MR. WALLACE: I am sorry. My experience only
7 goes as far as one hospital. I am satisfied how it would work
8 at our hospital, which is a teaching hospital. I would not
9 hazard an opinion, but I think that Dr. Galloway maybe has
10 something, that this would provide a means, a method, a vehicle
11 whereby a small hospital could organize its medical staff in
12 such a manner that there would always be one of the town's
13 medical men either on duty or available quickly, and this would
14 then make more fair -- because he was going to get some
15 remuneration -- it would probably make a more fair way of
16 providing medical care to that community. I think that until
17 Dr. Galloway mentioned it, I had never pictured that. But I
18 think that might be one excellent way of providing medical care
19 in a small community.

20 MR. MARTIN: I think Dr. Galloway's observation
21 is quite sound. The intent of our reference here is as against
22 a definition that of intern and residents there is about
23 four or five categories, I think it is, that have been jointly
24 developed and we refer to those in this sense. The type of
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1 sense would not be, in our minds, classified as an intern
2 because at this point they would be there for service and not
3 for educational purposes and while this, again, is semantics,
4 it would be read against, as I say, the definitions of these
5 categories -- interns, assistant residents and residents, but
6 we would tend to think of that other person, and they might
7 be referred to, that they wouldn't be there primarily for
8 education. So, this has had a joint development that we have
9 gone through in the last year or so with the Commission and
10 with the Ontario Medical Association; so that our observation
11 in relation to the payment would not apply to the individual
12 that Dr. Galloway is talking about. He would be a fully
13 licensed person.

14 MR. GALLOWAY: He would have to be?

15 MR. MARTIN: Yes.

16 THE CHAIRMAN: Mr. Caswell, do you mind waiting
17 for one more question? Mr. Whitney says this is right along the
18 line of what his particular question is.

19 MR. WHITNEY: You have raised it in your (11)
20 page, (j) in your summary, and I think Dr. Galloway has pointed
21 out something that is practical from the point of view of
22 contracts and drafting. I do not think this goes far enough
23 as justifying, in my mind, an amendment to the Bill. If you
24 think you can control that by contract, I think it would be
25 preferable to leave it there, from the drafting point of view.



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MR. WHITNEY: You have raised it in your (11) page, (1) in your summary, and I think Dr. Galloway has pointed out something that is practical from the point of view of contracts and drafting. I do not think this goes far enough as justifying in my mind, an amendment to the Bill. If you think you can control that by contrast, I think it would be preferable to leave it there, from the drafting point of view.



1 The second part that he has brought up, I think is very good.
2 I am of the legal profession and I know that in certain places
3 where services are required, but not continuously, that a
4 solicitor might be employed by an institution, say, for a
5 basic two or three thousand dollars to be there and to be in
6 an office and to be available and probably have nothing to do
7 some days; but he is paid a minimum stipend and then he is
8 permitted to do outside practice. Now, I think this is a good
9 contract arrangement to keep open. It seems to me, from the
10 professional point of view of the smaller hospital, that you
11 can work it very nicely, thereby having a contract with a mini-
12 mum stipend, a guarantee through the year, plus certain regula-
13 tions with respect to billing, the people they are seeing, and
14 being permitted to do outside practice. These are matters of
15 contract.

16 MR. DICK: I am thinking about who is going to pay
17 the \$3,000.

18 MR. WHITNEY: Generally, if the hospital wants
19 someone there, to have a sort of organized or partly organized
20 out-patient department, or something of this kind, that same
21 small hospital being built in some small community might very
22 well have to resort to this sort of thing because first they
23 can't afford maybe full-time medical staff and, secondly, they
24 have very little hope of getting interns, and so on. So I see
25 no objection, in my own thinking, to keeping this thing open.



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 no objection, in my own thinking, to keeping this thing open.



1 MR. DICK: I agree. But what I was referring to,
2 and smiling a little bit, possibly, while you were speaking,
3 Mr. Whitney, was how we were going to get this past Dr. Neilson,
4 to have it paid in the running expenses of the hospital. At
5 the present time, I am not quite sure.

6 MR. WHITNEY: To have what paid in the running
7 expenses of the hospital?

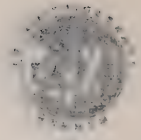
8 MR. DICK: To have this \$3,000 stipend.

9 DR. GALLOWAY: He may not be aware of the
10 O.H.S.C. Act that he is not permitted to do that treatment and
11 that individual payment would, in many instances, be adequate
12 to keep such a person there with no responsibility, no contract,
13 rather than as attendance, and his board and lodging, possibly
14 with the hospital? In other words, there would be no cost to
15 the hospital?

16 MR. DICK: Yes. I agree with Dr. Galloway.
17 Mr. Whitney has his approach to this in theory and in some
18 cases, no doubt, the fee or the honorarium idea would work out
19 also.

20 DR. BUTT: The stipend that you mentioned that
21 is paid to an intern or resident is paid by the hospital and
22 this is which you wish to amend, as I understand it, and for
23 which the resident or intern abrogates his position under this
24 Bill? This is what you wish?

25 MR. DICK: Yes.



MR. DICK: I agree. But what I was referring to,

to have it paid in the running expenses of the hospital. At the present time, I am not quite sure.

MR. WHITNEY: To have what paid in the running

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1 DR. BUTT: Now, do you state, then, that the
2 stipend paid is for educational purposes only and not for
3 services rendered?

4 MR. DICK: As I understand it, the stipend, or
5 whatever is paid to the intern, is for living assessment, more
6 or less.

7 DR. BUTT: No. But what reason are you paying
8 it? You are obtaining it from the O.H.S.C. for educational
9 purposes, not for professional services?

10 MR. DICK: That is correct.

11 DR. BUTT: If you so stated that, then you are
12 not taking away the doctor's position, which is what Dr.
13 Galloway, I believe, is saying, as being the doctor or physi-
14 cian under the terms of this Bill?

15 MR. DICK: That is correct.

16 DR. BUTT: Because if you do, you are now as a
17 hospital practising, not teaching. This is what I am trying
18 to say. If this is not clear, I wish you could clear it for
19 me.

20 MR. DICK: Mr. Chairman, as I understand it,
21 the hospitals are not interested, nor are the Hospital Associa-
22 tion interested, in fostering any arrangement which will indi-
23 cate that they are providing medical services. Medical
24 services are to be provided by the professional society and
25 the hospital is only a vehicle for making the services



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1 available to the patient.

2 THE CHAIRMAN: That is pretty clear.

3 DR. BUTT: Just to clarify what he means on
4 that...

5 MR. CASWELL: No. This is what I wanted to find
6 out, Mr. Chairman, whether their interns were going to, in
7 effect, be billing for their services and that the money was
8 going to be paid to the hospitals?

9 MR. DICK: No. That is not so.

10 MR. CASWELL: That is all.

11 MR. DICK: We do not wish to interfere in any
12 way with the professional relationship that may exist between
13 the doctor and the patient.

14 MR. CASWELL: I take it, Mr. Chairman, that they
15 are concerned about the economics because of the great diffi-
16 culty hospitals are having in financing and operating. I can
17 understand that. Thank you.

18 THE CHAIRMAN: You are finished, Mr. Caswell?

19 MR. CASWELL: Yes.

20 THE CHAIRMAN: Mr. Whitney?

21 MR. WHITNEY: Just to cover one matter that has
22 been referred to by Miss McArthur, the definition of "benefit"
23 in Section 1(a). That was your (11) page, sub-paragraph (1),
24 explained in paragraph 25. This point has been raised by
25 others before us; the question of whether the payment should



1 available to the patient.

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18 THE CHAIRMAN: You are finished, Mr. Caswell?

19 MR. CASWELL: Yes.

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21 MR. WHITNEY: Just to cover one matter that has

22 been referred to by Miss McArthur, the definition of "benefit"
23 in Section 1(a). That was your (11) page, sub-paragraph (f).
24 explained in paragraph 25. This point has been raised by
25 others before us; the question of whether the payment should



1 be made to the insured or to the hospital. There has been
2 wording suggested, such as "paid to the covered person," or
3 "on behalf of the covered person," and we have that pretty
4 well in mind and I do not think we need to go into it any
5 further, unless you do.

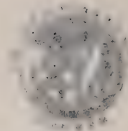
6 MR. DICK: Thank you very much.

7 DR. GALLOWAY: On page 1(c), you speak of out-
8 patient costs and I would like to clarify the fact that in
9 asking that these out-patient costs be paid for, that is from
10 the Ontario Hospital Services Commission that you are request-
11 ing it and not from the Medical Services Plan?

12 MR. DICK: That is correct.

13 DR. GALLOWAY: There are a number of us who are
14 extremely interested in out-patient departments. Has your
15 Association given any thought or projected any view for these
16 out-patient departments? What do you think will happen to them?

17 MR. MARTIN: I am sure Mr. Wallace will have
18 something to say on this, but the answer is yes in that,
19 particularly as it relates to the teaching hospitals, the
20 provision of some type of medical services insurance and
21 particularly to those who may be classified in a social assis-
22 tance category, will bring about a change in circumstances
23 that was foreseen when hospital insurance was made universally
24 available. The point that is touched on in the brief here is
25 in relation to the total teaching situation in which it is



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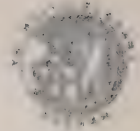
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1 probably visualized that as out-patient departments will be
2 vitally necessary for the ongoing teaching programs for medical
3 personnel, that these services will have to probably be substi-
4 tuted from the standpoint of having an economic basis as they
5 are now, because most of these people receive care in these
6 clinics at no charge by the profession. These clinics will
7 probably continue and they will be attractive to people from
8 the sense of the type of person that will be available in the
9 clinic setting to see them. It is only through the matter of
10 public understanding, we think, and the general organization
3 11 of the clinics as between the medical staffs in the hospitals
12 that it will be possible to continue this.

13 DR. GALLOWAY: Maybe I can ask this question of
14 Mr. Wallace directly. In giving this matter some thought, I
15 have been trying to protect both the teaching hospitals and
16 those who supply out-patient departments and wondering what
17 is going to happen to those monies that occur. Can I ask you
18 would there be anything in the Ontario Hospital Services
19 Commission Act for the operation of hospitals that would pre-
20 vent a physician or a group of physicians, which might be the
21 teaching staff of a hospital, from renting the space in the
22 out-patient department in carrying on a non-profit clinic
23 within the borders of the hospital?

24 MR. WALLACE: The concept of renting space to
25 the group of doctors who give that service has not arisen, has



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MR. WALLACE: The concept of renting space to
the group of doctors who give that service has not arisen, has



1 not been up for discussion in any hospital I know of. There
2 has been up for discussion the matter that the people at a
3 certain economic level in the community might still want to
4 come to the hospital, still want to come to the out-patient
5 department because there they get the medical opinion and the
6 medical advice, plus what we give them in laboratory services,
7 x-ray services, electrocardiograms and all these para-medical
8 benefits they get them there; whereas, if they take their
9 little ticket and walk in to a doctor's office, they get his
10 professional opinion. But then he might have to send that
11 patient to get an x-ray, send that patient to get an electro-
12 cardiogram, send him many places. So it is our hope that our
13 out-patient clinics will still continue to flourish because
14 they are a good place for young men who are learning to become
15 doctors. They are a good place for these young men, under the
16 guidance of the senior men, to learn how to deal with the run-
17 of-the-mill patient that they are going to see when they start
18 out to earn their living.

19 So we would hope that the clinics would still
20 flourish and still continue and I do not think that there will
21 be any problem when it comes to the doctors, the qualified medical
22 practitioners who give that service and who would be paid for
23 it. I do not think there would be any problem about them
24 taking the money, pooling it and dividing it in whatever
25 manner they see fit. That is one of the conversations that



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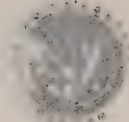


1 we have had at our hospital. Does that attempt to answer your
2 problem, sir?

3 DR. GALLOWAY: Yes; but only in part. I merely
4 am interested in the mechanics. We will receive a brief,
5 which is not yet up for discussion, from Dr. Hamilton's group,
6 who are the Deans of the faculties, and in trying to protect
7 your teaching hospital and out-patient departments, I was
8 wondering if this could be a mechanism which could be employed,
9 to simplify both the financing and the attracting of people
10 and if you can foresee, if this did prove to be practical,
11 any objection to your teaching group taking the space and
12 running their own teaching business in your out-patient depart-
13 ment?

14 MR. WALLACE: We really have not discussed that
15 or given it serious thought. It might be one thing. I would
16 tell you, though, that it is the opinion of our doctors that
17 they would prefer that the hospital did the mechanical busi-
18 ness of the thing. They would prefer not to have to set up a
19 separate and independent charging organization and recording
20 organization and receiving money, and so on - that they would
21 prefer - and this discussion has come up in our place, that
22 they would prefer the mechanics to be run by the hospital
23 accounting division and the hospital recording division and
24 that is as far as we have gone yet, sir.

25 DR. GALLOWAY: Thank you, sir. I have no



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DR. GALLOWAY: Thank you, sir. I have no



1 further questions.

2 THE CHAIRMAN: Are there other members of the
3 Enquiry who have questions? First, Dr. Hamilton. Are there
4 any other members?

5 MR. SIMON: I have one or two questions.

6 THE CHAIRMAN: Any others? We are ten minutes
7 overdue now. Is this going to present any problem?

8 DR. HAMILTON: I will tell you what my question
9 is. The operation of the hospitals in Ontario today costs
10 in the neighbourhood of \$300 million per year and, yet, the
11 services which these hospitals provide are still, or at least
12 there is still a lack of service in some areas and there needs
13 to be expansion in others.

14 Bill 163, as it is now written and as pointed
15 out in the brief submitted by the O.H.A., asks very clearly
16 what are the implications in Bill 163 on the exceptions in
17 Schedule A and I think that we should ask the Ontario Hospital
18 Association to explain, in considerable detail, what these
19 implications are. All laboratory services and diagnostic
20 services are excluded in Schedule A; rehabilitation services
21 are excluded, because they are hospital services.

22 I would also like to ask more about the out-
23 patient services. Does this include the emergency service in
24 every hospital? The point I am trying to make is, will Bill
25 163 throw an even greater burden on the hospitals and make them,



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1 even to a greater extent than they are already, the centre or
2 the basis of medical practice in the areas in which they are
3 situated?

4 THE CHAIRMAN: Am I right, Mr. Dick, that this
5 question may lead to very lengthy discussion here? I would
6 assume, at least, that this probably will not get a quick
7 answer. What I am trying to decide here is, should we break
8 and recess now and come back or can we clean this up if we sit
9 another ten minutes, realizing that we have a couple of other
10 questions?

11 MR. DICK: It is possible that we could clear
12 this up quickly. It is pretty nearly an open and shut argu-
13 ment, I think.

14 THE CHAIRMAN: Dr. Hamilton, if we delay going
15 over for lunch until 1 o'clock, would that make any difference?

16 DR. HAMILTON: No. That is all right.

17 THE CHAIRMAN: We will carry on until 1 o'clock;
18 but we do have to call a deadline here some time. You can
19 proceed, then.

20 MR. DICK: Thank you. I do not know that I am
21 qualified to answer this fully, but there are members here who
22 may volunteer to answer something. How about you, Mr. Martin?

23 MR. MARTIN: The first question raised by Dr.
24 Hamilton is the point that we had raised in (k). We are not,
25 at this point, recommending that the exception be changed, but



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MR. MARTIN: The first question raised by Dr. Hamilton is the point that we had raised in (a). We are not, at this point, recommending that the exception be changed, but



1 we want to make sure that the Enquiry understood the full
2 implications involved in this and maybe in this for the general
3 hospitals of the province. As we interpret the exception, the
4 laboratory services that are excluded here could lead to a
5 good deal of work being inflicted on the existing labs of the
6 general hospitals and, to a large degree, these facilities
7 are fairly heavily taxed at the present time. What kind of
8 arrangement is visualized in relation to the services that
9 are presently provided by the Government or commercial labs
10 was not clear to us. But we can only infer, from the exception,
11 the way it was worded, that a lot of this work might be refer-
4 12 red into the laboratory facilities of the public hospitals
13 and we would have a very difficult time, at least initially,
14 responding to the demands.

15 That was the first part of Dr. Hamilton's obser-
16 vation, I think.

17 DR. HAMILTON: In other words, could the
18 hospitals absorb increasing demands because there will be a
19 steadily increasing demand, and the Government laboratories
20 and private laboratories, possibly, from the way the Act is
21 worded, would be excluded?

22 MR. MARTIN: I think, generally speaking, this
23 was the point. The large hospitals where lab services would
24 be available, with which we are so concerned, they couldn't
25 initially handle - at least, if all this were dropped in our



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2 medical specialists who are involved and the technicians that
3 are involved. We are short of them now.

4 DR. HAMILTON: So that you could not stand any
5 increased pressure on those services at the present time?

6 MR. MARTIN: Yes. This is a fair statement,
7 and that we would want to know specifically what is the intent
8 - just how that is going to work with these exceptions in?
9 Our group were careful not to recommend that the exception be
10 removed because we realize that some of these laboratory
11 services should be performed under the supervision of the
12 medical specialists, but this is not done in the commercial
13 labs. But we raise caution here as to how this part of it is
14 going to be implemented.

15 DR. BUTT: Mr. Martin, would you feel, then,
16 that the professional component, which is really all Bill 163
17 is dealing with, can be paid?

18 MR. MARTIN: We do not interpret that Bill 163
19 only deals with the professional component, because it is the
20 O.M.A. tariff.

21 DR. BUTT: It is the O.M.A. tariff which has to
22 do with the professional services rendered by a physician.
23 Now, under the way the O.H.S.C. functions at the moment the
24 laboratory and diagnostic services and radiology, and so on,
25 are included in that as part of hospital service and in that



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25 are included in that as part of hospital services and in that



1 you are including the professional service. Would it be in
2 your interest, then, to say that extracting the professional
3 component out of the fee, or the bill, that this should be
4 covered under Bill 163? Do you follow what I said? It is
5 included in the total bill. If this portion were extracted,
6 would this relieve the pressure?

7 In other words, there would be payment for the
8 professional services paid for radiology, diagnostic services
9 in general, which are rendered by the physician? In other
10 words, it gives you another source of funds that you do not
11 have to pay for to the doctor who is rendering the service
12 and maintaining and looking after the lab. That is specifi-
13 cally what I mean.

14 MR. DICK: My only observation is that this
15 factor of laboratory services has been one which has covered
16 the Committee of the O.M.A. and the O.H.A. during the past
17 year.

18 DR. BUTT: I appreciate that. I am asking Mr.
19 Martin if this would not help rather than hinder his position.

20 MR. DICK: Mr. Chairman, so far we haven't come
21 up with any conclusion as to what the professional equivalent
22 is in the laboratory charge. Is that right, Dr. Butt?

23 DR. BUTT: Perhaps some of the groups that are
24 concerned therein could answer that.

25 MR. MARTIN: It seems to me that it still is a



component out of the fee, or the bill, that this should be covered under Bill 163? Do you follow what I said? It is in other words, there would be payment for the professional services paid for radiology, diagnostic services in general, which are rendered by the physician? In other words, it gives you another source of funds that you do not have to pay for to the doctor who is rendering the service and maintaining and looking after the lab. That is specifically what I mean.

MR. DICK: My only observation is that this factor of laboratory services has been one which has covered the Committee of the O.M.A. and the O.H.A. during the past

DR. BUTT: I appreciate that. I am asking Mr.

Martin if this would not help rather than hinder his position.

MR. DICK: Mr. Chairman, so far we haven't come

up with any conclusion as to what the professional equivalent

is in the laboratory charge. Is that right, Dr. Butt?

DR. BUTT: Perhaps some of the groups that are

MR. MARTIN: It seems to me that it still is a



1 question of workload that is involved here because you are not
2 suggesting that the professional physician is going to do all
3 of the work.

4 DR. BUTT: I am not. This is just for clarifi-
5 cation. I am merely stating that the professional component
6 which could be included within the Bill in normal circumstances,
7 and certainly read into it that way, would this be in disagree-
8 ment with your position? This is what I am asking.

9 MR. MARTIN: We do not know of any development
10 in that relation in the field of laboratories at the moment.

11 DR. BUTT: I know that. But would this be good
12 or bad from your position?

13 MR. DICK: I think it would complicate the
14 problem more than it would undertake to solve it.

15 DR. BUTT: That is from the hospital position?

16 MR. DICK: From the hospital position.

17 THE CHAIRMAN: Dr. Galloway?

18 DR. GALLOWAY: I have a minor question. You
19 insure hospital care for the patients and you also insure some
20 medical services. Does your interpretation of the Act let you
21 think that you will continue to carry on those extended health
22 benefits and insured medical services?

23 MR. DICK: I do not know if this has been under
24 discussion, but I would suggest that if we were providing some-
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24 discussion, but I would suggest that if we were providing some
25 thing at the present time of a peculiar nature, that it would



1 cause us to retire from that position - in other words, we
2 were providing service and if it was generally accepted and
3 used, I would hesitate to believe that we would withdraw it,
4 which I believe it is at the present time. We have a consi-
5 derable coverage in the major medical field.

6 DR. GALLOWAY: My interpretation of page 4 of
7 the Bill, No. 5:

8 "No carrier shall sell or provide or offer
9 to sell or provide any other form of medical
10 services insurance unless, (a) it offers
11 for sale and issues, (i) guaranteed renew-
12 able standard medical services insurance
13 contracts, and (ii) guaranteed renewable
14 standard in-hospital medical services
15 insurance contracts..."

16 This would cause your Association, if this Act
17 stays the way it is, to increase its insurance coverage very
18 considerably?

19 MR. DICK: Possibly.

20 MR. SIMON: Hospitals are not in the red now in
21 Ontario? In other words, are they doing all right financially?

22 MR. DICK: Yes. I think all our hospitals are
23 paid for the services that they render, except the out-patient
24 services in certain areas.

25 MR. SIMON: I think we have a pretty good



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19 Ontario? In other words, are they doing all right financially?

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21 paid for the services that they render, except the out-patient



1 hospital insurance plan in Ontario. But don't you think that
2 a good medical insurance plan would complement each other?

3 MR. DICK: I do not think we have any argument
4 on that score, Mr. Chairman, at all.

5 MR. SIMON: I am worried about the statement on
6 page 16:

7 "While it is difficult to predict what may
8 be the utilization experience of medical
9 services following the introduction of a
10 government-sponsored medical services
11 insurance plan, we are of the opinion that
12 the demand for such services will increase.
13 This could result in more people seeking
14 service at hospitals and there may be resul-
15 ting problems in supplying such service
16 immediately."

17 Do you mean to say that there are a few hundred
18 thousand people walking around sick in Ontario that would, all
19 of a sudden, go to the doctors and the doctors would send them
20 to the hospital? Is that your fear?

21 MR. DICK: No. That could be concluded from
22 that statement, no doubt. But I do not think that is entirely
23 what is meant. That as this type of service is made available,
24 the utilization of it is going to create ancillary services
25 which are provided by the hospital and, therefore, it could



page 16:

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MR. SIMON: I am worried about the statement on that score, Mr. Chairman, at all.
MR. DICK: I do not think we have any argument



1 relate into increased use of hospital facilities.

2 MR. SIMON: When people will be able to go and
3 see a doctor, the doctor will take care of them. They wouldn't
4 send them to the hospital or the out-patient hospital services,
5 as much as they do now?

6 MR. DICK: It could result in that. This is
7 our general observation.

8 MR. MARTIN: This would be unusual, I think,
9 because it was historically true that with the introduction
10 of the hospital insurance Bill, or the hospital insurance
11 program, the incidence of work that developed in the hospitals
12 in that did increase. There was no question about it. This
13 is not to say that it wasn't needed, but it did increase. The
14 group that got covered by this Bill for medical care could
15 easily originate more patients for the hospitals initially
16 and our reason for putting this in here is that we would hope
17 that, again, in some areas, as you know, in this province,
18 hospital care is a real problem now, particularly in the area
19 in which we are, and following the introduction of it, we would
20 hope that hospitals would not come in for the blame or inability
21 to provide the service at that point.

22 MR. SIMON: Bill 163 suggests two plans. It
23 has been suggested to us by some people that they would do
24 away with the in-hospital Schedule B because this will have a
25 tendency to have more people go into hospitals because they



relate into increased use of hospital facilities.

MR. SIMON: When people will be able to go and

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can have the same service go into hospitals and have



1 know that their doctor will be there and he will be paid for
2 his services. What is your experience in that regard? Do
3 people go into hospital because they know that they can get
4 service from the doctor there or will they stay away, if they
5 can get the service in another place?

6 MR. DICK: I think Mr. Wallace outlined that in
7 his suggestion in the out-patient area, that it is our obser-
8 vation at the present time that people are more and more
9 thinking of hospitals as a place to go when they require
10 either medical attention or emergency attention, and it follows
11 that that would naturally be the result. At least, it would
12 appear to us that way.

13 MR. MARTIN: I think again I might add that
14 this might be a question of semantics. We, for a good number
15 of years, did provide an in-hospital medical care program.
16 When the introduction of hospital insurance came along, we
17 transferred the contract to P.S.I. This was not so much a
18 question that people would get attention in the hospital,
19 but it was protection against those types of more serious
20 illness that require medical attention in a hospital. In
21 other words, they were really surgical procedures, medical
22 attention for hospitalized illnesses, and the fine distinction
23 is just the elimination of the home and office call portion
24 of the doctor's service. And I would think that we always
25 subscribe to the philosophy that the broad coverage program



know that their doctor will be there and he will be paid for his services. What is your experience in that regard? Do people go into hospital because they know that they can get service from the doctor there or will they stay away, if they can get the service in another place?

MR. DICK: I think Mr. Wallace outlined what is his suggestion in the out-patient area, that it is our observation at the present time that people are more and more thinking of hospitals as a place to go when they require either medical attention or emergency attention, and if follow that that would naturally be the result. At least, it would appear to us that way.

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1 was always best. But it would be, in my opinion, a question
2 of economics.

3 THE CHAIRMAN: Mrs. Aylen?

4 MRS. AYLEN: Mr. Chairman, a great number of
5 people in teaching hospitals are concerned about the fact
6 that they think teaching material will be reduced under Bill
7 163. Do you think it would be proper for every patient who
8 was admitted to a teaching hospital to sign a form to say
9 whether they would be teaching material?

10 MR. DICK: Possibly I am speaking personally
11 now, but without having been in on these discussions in a
12 major way, it would seem to me, from all I can read on this
13 matter, that there is a general tendency that the public are
14 accepting the principle of being in the teaching portion or
15 area as private patients and if a little more publicity were
16 given to this matter and orientation to that idea, that it
17 would be accepted by the general public.

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19 accepting the principle of being in the teaching portion of
20 the area as private patients, and if a little publicity were
21 given this matter, and orientation to that idea, it would be
22 accepted by the general public.

23 MRS. AYLEN: There are some hospitals in Canada
24 that carry it on?

25 MR. DICK: Yes, and from the information that's



of economics.

MRS. AXELSON: Mr. Chairman, a great number of

people in teaching hospitals are concerned about the fact that they think teaching material will be reduced under Bill 163. Do you think it would be proper for every patient who was admitted to a teaching hospital to sign a form to say whether they would be teaching material?

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MRS. AXELSON: There are some hospitals in Canada

MR. DIK: Yes, and from the information I have



1 come to my attention it has been accepted.

2 THE CHAIRMAN: Do you have any further comments,
3 Mr. Dick?

4 MR. DICK: None, other than this: that we're
5 very happy to come here and voice our opinions, and we stand
6 ready and willing to appear again, if there is anything else
7 that we can do that would be helpful.

8 THE CHAIRMAN: We have not been able to make
9 any arrangements for one of the afternoon briefs to be held
10 over for another day. We aren't able to contact these people,
11 so there's an obligation on our part to hear all that were
12 scheduled for today, which may run longer than our hearings
13 usually do.

14 What would be a reasonable time, Dr. Hamilton,
15 to set to come back?

16 DR. HAMILTON: I think we could be back by 2.15.

17
18 --- Luncheon adjournment.
19
20
21
22
23
24
25



THE CHAIRMAN: Do you have any further comments?

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/dpw 1 --- On resuming at 2:15 p.m.

2 THE CHAIRMAN: Is the delegation from the
3 Associated Medical Services here?

4
5 SUBMISSION OF ASSOCIATED MEDICAL SERVICES

6 INCORPORATED.

7 Appearances: Dr. J.A. Hannah
8 Dr. J.G. Palmer

9 THE CHAIRMAN: Are you alone on this, Dr. Hannah?

10 DR. HANNAH: Dr. Palmer is with me; my chief
11 medical officer.

12 THE CHAIRMAN: First of all, I apologize on behalf
13 of my colleagues here on the Enquiry for being a little late,
14 and the reason for that is that we wanted to finish up the
15 hearings that we had this morning, and we weren't able to get
16 away from here until after 1 o'clock. So that accounts for us
17 being a little late in getting back here. I hope that this
18 delay will not inconvenience you people.

19 I would like to read to you the instructions that
20 we read to all delegations.

21 Members of the Enquiry have received and studied
22 the brief you submitted. In accordance with the guide for
23 participation in hearings that was mailed to you, it will not
24 be necessary for you to read your brief, but you do have an
25 opportunity to emphasize or enlarge upon its conclusions or

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1 recommendations.

2 Members of the Enquiry may ask you questions on
3 the statements or recommendations submitted in your brief, but
4 you are not to be subjected to examination or cross-examination
5 by other persons.

6 It is not our intention to debate your suggestions
7 or recommendations, nor to state the views of this Enquiry on
8 them. Consequently, any opinions expressed in questions asked
9 or statements made by members of the Enquiry are intended for
10 clarification only.

11 As stated in the instructions, one person is to
12 act as your spokesman. However, if the spokesman feels that
13 another member is better qualified to answer a specific ques-
14 tion from a member of the Enquiry, the spokesman may receive
15 the Chair's permission to request the other member to answer.

16 The members of the press have requested a copy
17 of your brief, and if you have copies with you, perhaps you
18 will hand them to the members of the press at the conclusion
19 of your submission.

20 Dr. Hannah, are you to be the spokesman for the
21 Association?

22 DR. HANNAH: I am, sir.

23 THE CHAIRMAN: Please feel free to proceed, and
24 if you prefer to remain seated, you may do so.

25 DR. HANNAH: Mr. Chairman and gentlemen: we do



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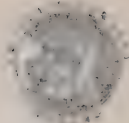
DR. HANNAH: Mr. Chairman and gentlemen: we do



1 appreciate the opportunity of this hearing, and I think that
2 perhaps, to save your time and ours, the crux of our proposal
3 can be found on page 14, paragraphs 6, 7, 8 and 9, to the end
4 of the presentation. Certain parts of that might be eliminated,
5 but the problem that we see in Bill 163 as it stands at the
6 present time is that it would eliminate the purposes for which
7 Associated Medical Services was incorporated; namely, to provide
8 a method of paying for a system of medical economics which
9 would pay for the cost of medical care in the community as it
10 is found by the doctor.

11 Now, as we see Bill 163, we go on a community-
12 rated basis, and certain other carriers have experience-rated
13 basis. This, in our opinion, would eventually result in unfair
14 competition, in that the person who can experience rate could
15 give a lower rate for the people in the younger group than the
16 community rating proposition could give, and as the individual
17 comes along in years, he could shift over to the community-
18 rated plan at a lower rate.

19 Now, at the present time, and for some years,
20 Associated Medical Services has carried on their plan with
21 an additional fee of 24 cents for a single individual and 40
22 cents for a family. We carry the individuals on through to
23 the grave on our group plans at the same coverage, with the
24 addition of this amount to the same price that everybody else
25 in those plans pay.



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1 The result of having to go into the pool would be
2 that these people in our organization who had belonged to us
3 for some years would be in the unhappy position of having to
4 step up from the rate they now pay to a rate which has been
5 suggested to be very considerably higher, and this, we feel,
6 would be unfair to these people, and would preclude the possi-
7 bility of us continuing to do that for these people.

8 Now, in our experience, for instance, the group
9 over age 65 are no more expensive to carry than certain other
10 groups, if you separate them off as individual groups, as is
11 being done with these people over 65. For instance, the
12 married women during the child-bearing period are very expensive
13 individuals. Indeed, they are more expensive, if you separate
14 them off as an individual group from the rest of the community;
15 they are more expensive than people over 65. That's our
16 experience, and we have some people on our plans now who have
17 reached the ripe age of 89, and this process has been gradually
18 developing since we started in 1937.

19 The first step in this direction was allowing
20 people to belong to us as long after they were 65 as they
21 belonged to it before. In the course of a few years we were
22 able to eliminate that restriction, and now we carry them
23 right through. Interestingly enough, the oldest plan on which
24 we have done this, our individual plan on which we started in
25 1937, has the best reserve of any of the plans that we have,



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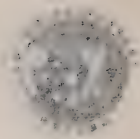
1 and we're asking that instead of it being compulsory for every-
2 body to take everybody that comes to them, irrespective of
3 whether they've had them previously or not, we're asking that
4 it just be compulsory for, for instance, Associated Medical
5 Services to have to provide for these people after they reach
6 the age 65, and we would not, of necessity, have to take people
7 over 65 that came to us from anyone else.

8 This would leave us in the position that we could
9 continue what we've been doing over the years, and we're at
10 the present time carrying a little better of the old people
11 than is found in the normal community. We have one individual
12 over the age of 65 for approximately ten individuals under the
13 age of 65.

14 Now, in the normal community that's somewhere in
15 the neighbourhood of one to eleven, or twelve. So that we've
16 been carrying our share of this load.

17 We have developed this over a period of years,
18 in the light of our experience, and have done it.

19 Now, this leads to other classes of people that
20 have to be attended to, and that the Government has said that
21 they want attended to. These are the people who are what are
22 known as the high-cost, or the uninsurables. Now, we have to
23 break these down into parts. I believe there are certain
24 people who have not taken advantage of the situation that has
25 existed, and which they might have taken during the last, 25



and we're asking that instead of it being compulsory for every body to take everybody that comes to them, irrespective of whether they've had them previously or not, we're asking that it just be compulsory for, for instance, Associated Medical Services to have to provide for these people after they reach the age 65, and we would not, of necessity, have to take people over 65 that came to us from anyone else.

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1 years, before they developed any chronic condition, or became
2 older. The vast majority of them could have had some sort of
3 coverage. However, they did not take it. Now I propose that
4 this is the only area in which there should be a necessity for
5 pooling the cost. The people who have not taken advantage of
6 what is available to them up to the present time should be
7 given the opportunity of coming in, but I believe that oppor-
8 tunity should be limited. I'm of the opinion that these people
9 aren't going to be any more prudent in the future than they
10 have been in the past, and it will only be when they have need
11 of someone to pay their bills that they will begin to think
12 of the necessity of being in.

13 However, I think in order to give everybody a
14 fair chance, and to cover everybody in the province, these
15 people could be put into a pool, and we believe it would be
16 fair for every one of us carriers to share the cost of those
17 people. This would become a diminishing entity if each carrier
18 had to carry his own responsibility through after the age of
19 65, and when they become high-cost.

20 So that this would leave us in the position that
21 we would not have to go to these people, the old people, and
22 tell them that these rates are going up.

23 Now, the other group of people who would have to
24 be looked after is the high-cost group of people who might
25 enroll in groups in the future. Where already the prepaid

1 years, before they developed any chronic condition, or became
 2 older. The vast majority of them could have had some sort of
 3 coverage. However, they did not take it. Now I propose that
 4 this is the only area in which there should be a necessity for
 5 pooling the cost. The people who have not taken advantage of
 6 what is available to them up to the present time should be
 7 given the opportunity of coming in, but I believe that oppor-
 8 tunity should be limited. I'm of the opinion that these people
 9 aren't going to be any more prudent in the future than they
 10 have been in the past, and it will only be when they have had
 11 of someone to pay their bills that they will begin to think
 12 of the necessity of being in.

13 However, I think in order to give everybody a
 14 fair chance, and to cover everybody in the province, these
 15 people could be put into a pool, and we believe it would be
 16 fair for every one of us carriers to share the cost of these
 17 people. This would become a diminishing entity as each carrier
 18 had to carry his own responsibility through after the age of
 19 65, and when they become high-cost.

20 So that this would leave us in the position that
 21 we would not have to go to these people, the old people, and
 22 tell them that these rates are going up.

23 Now, the other group of people who would have to
 24 be looked after is the high-cost group of people who might
 25 enroll in groups in the future. Where already the prepaid



1 plans have already carried these people there is no distinc-
2 tion between them, and they are in groups. We do not propose
3 that we should ever shift them out. We have not done so, and
4 so there is this group that has to be looked after. We feel
5 that they should be part and parcel of the group, and should
6 not have to go into any other group, and be pooled. We are
7 prepared to handle these, and have done so throughout the
8 years. This has not been something that we said we didn't do
9 it yesterday, and we do it today. It has been something that
10 has developed by experience over the period of the 26 years
11 that we've been trying to operate.

2 12 So that we feel if there's one small change made
13 in the Act by the addition of two sections, one section to
14 Part 5 of the Act, and additional to Part 6. This I have set
15 out on page 16 of our presentation, and it, in effect, in our
16 opinion, does what we've suggested would enable us to carry on
17 in the way that we've been carrying on throughout the years,
18 and as I understood it it is the intention of the Government
19 to bring this Act in and disturb as little as possible the
20 ordinary methods by which carriers have been carrying on their
21 business.

22 Now, this, in our opinion, would leave the field
23 open to ordinary competition, and this, we believe, is good,
24 and would be good for the situation.

25 THE CHAIRMAN: Thank you, sir. Some of the



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tion between them, and they are in groups. We do not propose
that we should ever shift them out. We have not done so, and
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open to ordinary competition, and this, we believe, is good,
and would be good for the situation.



1 members of the Enquiry have indicated a desire to ask some
2 questions of you.

3 Miss Carpenter?

4 MISS CARPENTER: Mr. Chairman, I would defer to
5 somebody else.

6 THE CHAIRMAN: Mr. Naylor?

7 MR. NAYLOR: Perhaps Dr. Butt should ask his
8 first.

9 DR. BUTT: Well, Mr. Chairman, this is an
10 interesting position, because I know Dr. Hannah, and I must
11 admit that - this is off the record because this is a personal
12 observation - anyway, we know each other, so I'll continue
13 with that.

14 I guess this is why they thought maybe I should
15 ask some questions, and I'm sure you can answer them all.

16 You say it's essential that a limit be placed
17 on the time permitted for these people to join. Could you give
18 me some of the details of the length of time that there should
19 be open enrollment, or, shall I say one month, two months; the
20 number of times per year, or is this what you have in mind?

21 DR. HANNAH: Mr. Chairman, I have in mind that
22 if these people are ever going to make up their mind on the
23 basis of actually just wanting coverage, instead of just wanting
24 somebody to pay their bills ---

25 DR. BUTT: Well, we all like that situation.



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THE CHAIRMAN: Mr. Mayhew?

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basis of actually just wanting coverage, instead of just wanting

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1 DR. HANNAH: But it's my contention that these
2 people should be given a reasonable length of time after the
3 Act is promulgated, say, one, two, three, four months, in
4 which they have the opportunity of enrolling. Following that
5 I think they should be made responsible for their own negli-
6 gence, and not be permitted, by law and legalized, to come to
7 any carrier and say, "I want the standard plan at a price,"
8 when they know that they are going to have some expensive
9 procedure in the offing.

10 So that I would limit it to a period of about
11 three or four months, and not more than one opening, maybe
12 under pressure, too.

13 DR. BUTT: Well, then, would there not be any
14 further enrollment periods, say, one or two years hence? Or
15 is it limited to just this one time, and that alone?

16 DR. HANNAH: No, it would just be the one time
17 as far as I'm concerned, except for those people who might
18 move into the province from another province, or from outside,
19 and did not have a coverage. Those people should, I believe,
20 not have to wait for an opportunity to join, but the people who
21 are here and are residents at the date of opening, I believe
22 their time should be limited to three or four months.

23 DR. BUTT: Could they get the standard plan in
24 the future at, shall I say, a special rate, or a certain amount
25 extra to be paid, or do you feel it should be cut off completely?



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the future at, shall I say, a special rate, or a certain amount
extra to be paid, or do you feel it should be cut off completely



1 DR. HANNAH: No, I would not have it so, because
2 that gives them the opportunity -- for instance, as a doctor,
3 you know that there are a good many conditions that are what
4 we call operations of election.

5 DR. BUTT: Right.

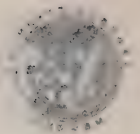
6 DR. HANNAH: And I, as a patient, might come to
7 you, as a doctor, and you might say to me, "Well, Hannah, you
8 have a hernia, you have a gall bladder," or a thousand-and-one
9 other things, and you probably couldn't get a bed for me any-
10 how inside of three months, and if you could get me a bed
11 inside of three months, and my waiting period wasn't up, it
12 would be easy enough to put it off another two months, and I
13 would not have to pay anything until I knew that I had a gall
14 bladder or a hernia, or what-have-you, to be performed.

15 This, to me, is unfair to the people who have
16 been prudent enough to make provision during the time they are
17 well.

18 DR. BUTT: In paragraph 7, on page 4, you say
19 that:

20 "A.M.S. has considerable reservations that
21 it will be possible to persuade the balance
22 of the population to 'voluntarily' sign up,
23 irrespective of the terms offered."

24 You don't feel that the subsidy, or partial
25 subsidy, no matter how great, would be of any value as an



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DR. BUTT: In paragraph 7, on page 4, you say that:

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1 incentive to people to sign up? You feel that it has to be
2 mandatory, or compulsory, for them to do this?

3 DR. HANNAH: I don't say that. For instance,
4 every carrier is going to have the same plans in existence as
5 they have at the present time, and the Act proposes that there
6 will be a standard plan put in, and the maximum, a maximum,
7 set for such standard plan. Any proposals I've heard so far
8 proposed a maximum price much greater than anything that
9 existed, or greater than anything that exists at the present
10 time, and therefore, if they have not been prepared to take
11 advantage of the situation at the lesser rate, I don't see
12 that the introduction of a plan at a higher rate is going to
13 be any induction on their part to come in.

14 DR. BUTT: Yes, but I mentioned the subsidy,
15 Dr. Hannah?

16 DR. HANNAH: Oh, those people, yes.

17 DR. BUTT: Those are the ones I was referring
18 to in this particular instance.

19 And then you say in paragraph 8 that:

20 "That body will continue to dodge its
21 responsibility ---"

22 Do you mean the people who you have previously
23 outlined, who will have an operation, and contemplate deferring
24 their paying of their responsibility in the long term?

25 Is this what we're to infer from that?



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1 DR. HANNAH: Yes.

2 DR. BUTT: Later on you say something that
3 bothered me, to the effect that the insurance people, or some-
4 body, had something to do with writing the Bill, but there was
5 a sub-committee, I believe you knew of this, on February 27th,
6 1963, and were you not in one capacity or another part of that
7 group, the Sub-Committee on Mechanics?

8 DR. HANNAH: I was; that's right. But this was
9 not the drafting of the Bill.

10 DR. BUTT: I believe it's more or less in confor-
11 mity with the mechanics that are given in this particular
12 brief.

13 DR. HANNAH: Bill 163, as I understand it, was
14 drafted in ---

15 DR. BUTT: I'm sorry. I just wanted to bring up
16 the point, not really to debate the thing.

17 DR. HANNAH: Well, I still stick with my point,
18 that we were not represented at the drafting of the Bill.

19 DR. BUTT: Well, I think that that is about all
20 I have at the moment.

21 MR. WHITNEY: Mr. Chairman, Dr. Hannah: this
22 will take a little while, that's why I suggested that you sit
23 down.

24 The field you've been in, as we all know, is
25 the field that practically coincides with the field that Bill



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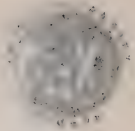
3 3 So that your brief, like some of the other
4 briefs, the Co-Op, and various briefs of that kind, are pretty
5 much of a major concern to us, because you have a lot of the
6 answers and suggestions from actually operating in a field
7 which this Bill is going to, in a sense, sort of blanket, or
8 have to do very much with.

9 So there are a number of questions which we
10 would like to put to you, to enlarge our knowledge on this
11 situation, and we'll be guided, as we go along, and we're
12 keeping very much in mind, as I say, the groups like Windsor
13 Medical Services, your own, and so on, these groups that have
14 been operating in this field.

15 As far as I'm concerned, and from what I've
16 seen so far, and heard so far, as a member of the Committee,
17 this consideration goes to the extent of not doing anything
18 that's unnecessary to disturb present situations, but with a
19 view more or less to harness the whole situation, and yet do
20 something in the public interest, and that's the standard
21 contract idea.

22 Now, I have quite a few questions, and I would
23 like to start, without any particular logical order, to going
24 through your brief, and asking you these questions.

25 First of all, on your page 1, in the boxed



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1 section, in No. (c), in the Objects of your Charter, and I'm
2 aware, as a lawyer, that objects are drawn on a fairly wide
3 basis, so that resort might be had to them if it were seen fit
4 in the future for a corporation to do so -- could you tell me
5 how much has been spent under Item (c) on research by Associ-
6 ated Medical Services?

7 Are you actually in that field, and to what
8 extent, and how do you measure it?

9 DR. HANNAH: Since we've started, sir, we've
10 published our costs; the cost of taking off the statistics,
11 which is not inconsiderable, and wasn't inconsiderable at the
12 outset.

13 We've made those statistics of that experience
14 available to anybody who wishes to use it, and I would think
15 that in the process of administering a plan this might have
16 cost us somewhere in the neighbourhood of, say, one-and-a-half
17 to two per cent.

18 MR. WHITNEY: Of the gross premium collected?

19 DR. HANNAH: I would think that would be about
20 it.

21 MR. WHITNEY: And that's confined to research.
22 Have you done anything on the preventive medicine angle?

23 DR. HANNAH: No.

24 MR. WHITNEY: Nothing yet?

25 DR. HANNAH: No.



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MR. WHITNEY: And that's confined to research?
DR. HANNAH: No.
MR. WHITNEY: Nothing else?



1 MR. WHITNEY: You've also mentioned, in your
2 talk ---

3 DR. HANNAH: Unless it be considered that
4 making it possible for people to get certain services they
5 might not otherwise have been able to do is in that field.

6 MR. WHITNEY: You've also mentioned reserves
7 in your talk?

8 DR. HANNAH: Yes.

9 MR. WHITNEY: Perhaps we can cover these next
10 two or three points I have in one.

11 If you publish a financial statement to your
12 members, and we have asked this of others, too, to give us
13 this assistance if they wish to give it. We would like to
14 have, if you have it, a financial statement, and I suppose
15 therein it would show the reserves that you are concerned
16 about people not infringing upon unfairly, or that have been
17 built up by prudent people.

18 DR. HANNAH: I didn't get that.

19 MR. WHITNEY: You talk about retaining reserves
20 for the security of the plans that you are operating. Do you
21 have a financial statement that shows the operating figures
22 and the reserves, and so on?

23 DR. HANNAH: Yes.

24 MR. WHITNEY: Could we have that?

25 DR. HANNAH: Oh, yes, that's available to anybody



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1 that wants it.

2 MR. WHITNEY: Good. On page 2, in number 3,
3 and these next few questions may, in a sense, overlap. We're
4 going to have to talk a bit about these.

5 You mention in 3:

6 "That the threat of destruction of the
7 prepaid concept will be eliminated if
8 Sections 5 and 6 of Bill 163 are altered
9 so that each carrier must accept respon-
10 sibility on the standard plan for any and
11 all residents who may be terminated for
12 any reason from any of that carrier's
13 plans, so that they will be covered not
14 only during the 'healthy' and 'profitable'
15 period of life but all the way to the
16 grave. This has been done by the Prepaid
17 Plans for up to 25 years."

18 Now, the standard contract that the Bill
19 envisages, and it probably goes to the root of policy here in
20 this Bill, so that substantially it will be carried through,
21 I would expect, no matter what our recommendations are, but
22 we're free to make recommendations, this Enquiry, as to varia-
23 tions, but assuming for the moment that there is a standard
24 contract, that the Bill mentions it, that it stays in the
25 Bill, and this would be the device which would be used, the



1. 1000-1000-1000

2. MR. WHITNEY: Good. On page 2, in number 2,

3. going to be in the same way.

4. You mention in 3:

5. "That the threat of destruction of the

6. prepaid concept will be eliminated if

7. Sections 5 and 6 of Bill 103 are altered

8. so that each carrier must accept respon-

9. sibility on the standard plan for any and

10. all residents who may be terminated for

11. any reason from any of that carrier's

12. plans, so that they will be covered no

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15. grave. This has been done by the Prepaid

16. Plans for up to 25 years."

17. Now, the standard contract that the Bill

18. I would expect, no matter what our recommendations are, but

19. we have tried to make recommendations. This is the only way to

20. make, but we have the two standard that have been

21. continued. But the Bill that is in the House is the

22. Bill, and this would be the service which would be available



1 intention of that contract is to make it guaranteed renewable
2 and non-cancellable.

3 Now, does this answer your problem in Section 3?

4 DR. HANNAH: Not quite, sir. As the Act stands,
5 it makes it mandatory for, for instance, Associated Medical
6 Services, to accept anybody who comes to them and demands a
7 standard plan, and they have to give it to them.

8 What I'm proposing is that the only person who
9 would have to give them the standard plan, or any plan, is the
10 carrier that had them previously.

11 Now, this is apart from the people who come
12 into this pool that I spoke of separately, but I'm talking of
13 the people who are carried in groups.

14 Now, this would not compel any other carrier
15 to take the people from any other class. That is, A.M.S.
16 would not have to take it from the X Plan, or the X Company,
17 but we would have to take it for our own.

18 Now, this would permit us to continue to give
19 the people who were with us during their period of stay,
20 continue the thing that we're doing at the present time on our
21 present rates, whereas, if we have to join a pool, we would,
22 of necessity, have to go to the maximum rate, which would be
23 more than we're charging these people at the present time.

24 MR. WHITNEY: Well, it struck me there was an
25 implication on page 3, in the first two or three lines, that



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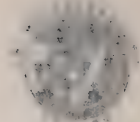
1 this idea of termination, which again is raised throughout
2 your brief, but accepting the doctrine of the universally
3 available standard insurance, that it must be universally
4 available, and I know this brings in Dr. Butt's questions to
5 you about having a first and open enrollment period, and there-
6 after no open enrollment period, and I'm not too sure where
7 that leaves us, but the type of termination that's envisaged
8 so far as termination by the person who doesn't pay his premium,
9 or who may be terminated for fraudulent misrepresentation --
10 the Bill says misrepresentation.

11 DR. HANNAH: No; but he may be terminated off a
12 plan that he had, for instance, prior to reaching the age of
13 65.

14 MR. WHITNEY: There's nothing in the Bill that
15 allows a carrier to terminate because a man begins to reach a
16 certain age.

17 DR. HANNAH: Not if he has a standard plan,
18 but if he has another plan, a plan other than the standard,
19 which I presume always would continue, that we might have, for
20 instance, say, A.M.S. has some 200,000 people on a type of
21 plan ---

22 MR. WHITNEY: So you are expressing caution to
23 us, then, that if someone is under a lesser type plan, or
24 some plan where he might be terminated, either by himself or
25 by the company, that then he might come to someone else and



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19 MR. WHITNEY: So you are expressing caution to
20 us, then, that if someone is under a lesser type plan, or

21 some plan which is not a standard plan, that it might be possible
22 to have a plan which is not a standard plan, that it might be possible



1 ask for a standard plan?

2 DR. HANNAH: Yes. I think that we should be
3 given the opportunity, if we can, on our people of carrying
4 them at a lesser rate than the standard plan, even after they
5 reach the age of 65.

6 MR. WHITNEY: Well, let me clear that up. The
7 words "maximum" and "rate" aren't identical here. Maximum
8 means that there is a ceiling on it.

9 DR. HANNAH: Yes, I know.

10 MR. WHITNEY: In experience different carriers
11 compete below the maximum, with different rates.

12 DR. HANNAH: Yes, but there's nothing in the
13 Act that prevents, for instance, Associated Medical Services,
14 on any of the people that they are carrying at the present
15 time that aren't on the standard plan we will say, for instance
16 that the Act goes through, and there are a certain number of
17 people on the standard plan. Now, I recognize that it's non-
18 cancellable for the people that are on that standard plan,
19 they can't be cancelled according to the Act, but the people
20 who are on plans other than the standard plan, if they retire
21 at the age of 65 there's nothing in the Act that prevents the
22 carrier from cancelling him at the age of 65. Indeed, it must
23 be presumed that if the high costs are going to be pooled, they
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1 DR. BUTT: No, they don't have to cancel them
2 to pool them.

3 DR. HANNAH: But he would have to pay the stan-
4 dard rate if he goes in the pool.

5 DR. BUTT: The maximum, yes.

6 MR. WHITNEY: Yes; the pooling is very much apt
7 to be the maximum, because you've got bad risks.

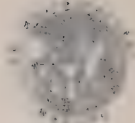
8 DR. HANNAH: Yes, and so far as we're concerned
9 in A.M.S. we would like to be able to say if we can provide it
10 for our own people at less than the maximum rate, then there's
11 no reason that I can see why we shouldn't be able to do so.

12 THE CHAIRMAN: May I step in here for clarifica-
13 tion? I understand that you are saying that you could not
14 offer the standard plan for less than the maximum, that the Act
15 would not permit you to offer the standard plan for less than
16 the maximum?

17 DR. HANNAH: No, that's not what I'm saying, sir.
18 I'm saying that if we have got to go in a pool, we have to go
19 in at the maximum rate, or else we can't be in the pool.

20 You can't pool anything that's not at the maxi-
21 mum rate.

22 MR. WHITNEY: Oh, well, it's theoretically
23 possible that the maximum may not apply in the pool. I had
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25 when you are taking the selections against the carrier into the



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2 nothing in the Act that says, and there are no regulations
3 drawn yet for this Act, there's nothing in the Act that says
4 the pool must be the maximum rate.

5 DR. HANNAH: But you can't go into the pool
6 and pool them unless you do charge the maximum rate, as I
7 understand it.

8 DR. BUTT: No.

9 MR. NAYLOR: No.

10 MR. WHITNEY: No.

11 DR. HANNAH: Do you mean that if the maximum
12 rate is \$15, are you saying to me that Associated Medical
13 Services might take the standard plan, and put it out at \$10,
14 and put these people in the pool?

15 MR. NAYLOR: That's possible. I mean, we don't
16 know how this may end up. Of course, every carrier, including
17 A.M.S. would have to pay the pool the same net premium for all
18 policies put in the pool, which would be something less than
19 \$15, but you might have the right to charge whatever you wish.

20 DR. HANNAH: But I would not have the right to
21 pool them, surely?

22 MR. NAYLOR: Yes.

23 DR. HANNAH: And share in the distribution of the
24 cost?

25 MR. NAYLOR: Yes. As long as you paid the same



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2 DR. HANNAH: Yes. There's the crux of the
3 matter. I must pay the same as any other carrier to that
4 pool, which, why wouldn't it be the maximum? I've sat in on
5 discussions of what is considered to be the maximum, and what's
6 considered necessary for the maximum in this pool is higher
7 than our rates.

8 MR. WHITNEY: Well, that could be. I still
9 think that's all right.

10 In No. 4, on page 3, you mention the "dumping"
11 of the liability.

12 I presume this is still pretty much the consi-
13 deration we are discussing?

14 DR. HANNAH: Yes.

15 MR. WHITNEY: What I'm suggesting to you, to see
16 whether it's workable, and the Enquiry is here for you to tell
17 us the answers so that we can gather this information and know-
18 ledge -- supposing the case did come up that someone is under a
19 lesser than standard plan, then he applied at your offices for
20 what is supposed to be under the general doctrine of this Act
21 universally available, he applies for the standard plan at 64
22 years of age, and you didn't want him.

23 Now, I don't know what the pooling arrangements
24 are all going to be. They aren't spelled out yet, but if you
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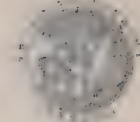
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7 take that man at a rate that we wanted to charge him, other
8 than the maximum, but as I understand the discussion that has
9 gone on in regard to pooling, it's that you could only pool if
10 you charge the maximum rate.

11 MR. WHITNEY: Oh, I think what you are saying
12 now -- are you saying this: that in setting your standard
13 contract rate you might want to set it at 90% of maximum, but
14 this would require you to take all the people who you consider
15 are selections against you, and with this 90% rate you might
16 not have enough money to pay your pro rata premium in the pool
17 when you put this case into the pool?

18 DR. HANNAH: As it stands at the moment.

19 MR. WHITNEY: Is that what you are saying?

20 DR. HANNAH: That's what I'm saying, as it
21 stands at the moment, by carrying our own risks, our own people
22 that are high cost and are over 65, we know by experience that
23 we can carry these. We have our fair share, a cross-section
24 of the population, therefore we know what it costs, and we're
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1 MR. WHITNEY: You see, on the standard contract
2 you are still able to charge what you will below the maximum,
3 but on your experience you feel you can go at 80% of maximum
4 and do fine, but suddenly you get a terrible case, which has
5 to be pooled, and you know that the 80% standard rate you are
6 quoting isn't going to be sufficient for the pool?

7 DR. HANNAH: I have to have that rate for
8 special selection.

9 MR. WHITNEY: It's an interesting feature of
10 this pooling arrangement.

11 DR. HANNAH: Well, unfortunately it isn't
12 spelled out anywhere I know of, although there has been a
13 great deal of discussion, and all the discussions I've heard
14 seem to be directed on the fact that there will be a pool.

15 MR. WHITNEY: Throughout your brief you do --
16 as I say, these things overlap -- you do sort of hit at this
17 question of universally available.

18 I think the thought so far is that - and I want
19 to see if this meets with your approval, and you can tell us --
20 if my statement sounds like a statement, it's really meant to
21 be a question -- if there is an open enrollment at the
22 beginning, of three months, and it's worked out by Medical
5 23 Carriers Incorporated, however it's worked out, for those who
24 subsequently apply for coverage under a standard contract, if
25 there is a suitable waiting period established, would this

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1 bother you, if the waiting period were sufficient protection
2 against the person who just wants to buy a new hat because he
3 lost one ten minutes ago sort of thing?

4 DR. HANNAH: No, I'm sorry, sir. I don't think
5 -- my contention is this: that these people have knowledge of
6 - they can wait till they have knowledge of a condition which
7 can wait to be attended to. It's true that in the meantime,
8 if they step in front of a car and get a broken leg or a
9 broken arm, they aren't covered, but they've taken that chance
10 and are prepared to continue taking it. But they do go to a
11 doctor and get a diagnosis, and it doesn't matter what sort of
12 a waiting period you put on it, it won't be enough to counter-
13 act the fact that that operation will cost hundreds of dollars.

14 If you have three months' waiting period, and
15 your subscription rate is \$15, it will cost \$45 to have an
16 operation that may cost you \$250.

17 MR. WHITNEY: This problem is not a new problem.
18 This is a problem that always plagues the insurance industry
19 and I, like you, have had some connection with it for some 25
20 years, too.

21 We've always found in the industry - and I'm
22 going to ask you if your experience is the same - that when
23 we take on new groups, in the first year they get everything
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11 it's pretty tough to sell a healthy man, who's pretty confident
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13 DR. HANNAH: Are you thinking along the same
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15 MR. WHITNEY: What I am saying to you is in
16 your statistical analysis of your business, have you found
17 that the first year is generally a heavier claim year than the
18 subsequent years?

19 DR. HANNAH: No. I am afraid I have not.
20 That is not our experience. But I wonder if we are thinking
21 in equal terms, and I want to be sure of this before I go
22 further. You did mention group business and you said most of
23 your experience was in connection with a group.

24 Now, you went on to state
25 that it is the individual who is faced with a possibility of
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1 different situations.

2 MR. WHITNEY: Two different situations, yes.

3 DR. HANNAH: But in your group, the fact that
4 you take on a group, you level out the risks against you.
5 By virtue of taking a group, you get the well with the ill,
6 and so on, the fellow that is expecting an operation and the
7 fellow that is not expecting an operation, and if your percen-
8 tage of the group is high enough and your group is large
9 enough, that equals out.

10 Now, our actual experience is that for the first
11 two years of our operation - and I learned this the hard way,
12 because I thought that we were charging too much and was almost
13 about ready to reduce the rate; that after the second year, we
14 found that the reserves started to go the other way and it took
15 them a little while to level off again. So that that was not
16 quite our experience.

17 In the first twelve years we operated, we only
18 operated on an individual or a family group basis and this was
19 our experience in the first twelve years of operation.

20 THE CHAIRMAN: Mr. Naylor?

21 MR. NAYLOR: I have one or two questions, Mr.
22 Chairman. I am still not entirely clear in my own mind, Dr.
23 Hannah, as to the reasons for the changes in the wording
24 suggested in Clause 5, set out on page 16, and the effects of
25 it.



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2 it does now provide that if a resident ceases to be covered
3 under a group plan that it is the responsibility of the carrier
4 of that group plan to issue a standard contract to him. That
5 is in the Bill now.

6 DR. HANNAH: That is quite true. But it is also
7 mandatory on any other plan to provide him with coverage if he
8 asks for it.

9 MR. NAYLOR: This is during the initial enroll-
10 ment period?

11 DR. HANNAH: No. An individual, as I understand
12 it, may decide that he wanted to leave his original carrier and
13 come to Associated Medical Services and ask us for the standard
14 plan and we have no alternative but to give it to him.

15 MR. NAYLOR: I do not see that in the Bill.

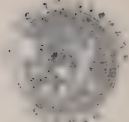
16 DR. HANNAH: It doesn't say it in those words.

17 MR. NAYLOR: It says "by such carrier," in
18 Clause 13, which refers to a carrier which has been carrying
19 the group plan.

20 THE CHAIRMAN: I would interpret it that way,
21 Mr. Naylor.

22 DR. HANNAH: Clause 5, I think, Mr. Chairman,
23 indicates that you have no choice in the matter.

24 MR. NAYLOR: Yes. But after the initial enroll-
25 ment period, you would only have to offer a contract with



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DR. HANNAH: It doesn't say it in those words.

MR. MAYLOR: It says "by such contract," in clause 13, which refers to a contract which has been covering the group plan.

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indicates that you have no choice in the matter.

MR. MAYLOR: Yes. But after the initial enrollment period, you would only have to offer a contract with



1 waiting periods; whereas under this Clause 13, the obligation
2 on the carrier of the group plan is to issue to the individual
3 being terminated under the group plan the standard contract,
4 without waiting period?

5 DR. HANNAH: But does Clause 13 say anywhere
6 that, for instance, we can refuse to accept such an individual?

7 MR. NAYLOR: I do not see anything in the Act
8 which says that you are required to.

9 DR. HANNAH: But under 5, it does, and that it
10 is not just applied to the initial enrollment period. It is a
11 clause that affects the whole set-up, as far as I can read.

12 MR. NAYLOR: Perhaps we do not have to labour
13 that point. Another part of this question has to do with the
14 initial enrollment period. As I understand your wording and
15 your proposal, you would require any carrier to offer the
16 standard plan during the initial enrollment period only to
17 residents who have no form of medical coverage at all with any
18 carrier; is that what you mean?

19 DR. HANNAH: Frankly, I hadn't thought of any
20 other possibility. I was thinking in terms of those people who
21 have not yet taken any form of coverage. I was leaving the
22 other people who are enrolled in groups at the present time
23 and I must admit that I hadn't thought of anyone enrolled in a
24 group going over to such a plan because, as I understand it,
25 the rates for such a standard plan will be higher than the



1. ...
2. ...
3. ...
4. ...
5. DR. HANNAH: But does Clause 13 say anywhere
6. that, for instance, we can refuse to accept such an individual
7. MR. NAYLOR: I do not see anything in the Act
8. which says that you are required to.
9. DR. HANNAH: But under 5, it does, and that it
10. is not just applied to the initial enrollment period. It is a
11. clause that affects the whole set-up, as far as I can read.
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1 group rates.

2 MR. NAYLOR: I do not know. I do not think I
3 made myself clear. Let us leave group out of the picture for
4 the moment.

5 DR. HANNAH: Right.

6 MR. NAYLOR: Residents of the province may have
7 various forms of individual medical coverage, ranging from a
8 very limited form of coverage to a fully comprehensive plan?

9 DR. HANNAH: Yes.

10 MR. NAYLOR: Now, are you saying that any such
11 person shall have the right, during the initial enrollment
12 period, to buy a standard plan only from their present carrier,
13 that they cannot go to any other carrier?

14 DR. HANNAH: I think that would be fair enough.

15 MR. WHITNEY: Would you make it compulsory,
16 compel them to enroll with their own carrier?

17 DR. HANNAH: No. If they did not want to enroll,
18 that is the purpose of the Act, as I understand it, that they
19 will not have to enroll; but if they want to, I say that they
20 should take it from the people that they were with previously.

21 MR. WHITNEY: You are not suggesting a change
22 in the Bill on that score?

23 MR. NAYLOR: Oh, yes. They are.

24 MR. WHITNEY: Well, let us be sure of this.
25 You are suggesting that the right to purchase the standard



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MR. WHITNEY: Well, let us be sure of this.

You are suggesting that the right to purchase the standard



1 plan for any individual resident who now has some form of
2 medical coverage be limited to his present carrier, aren't you?

3 DR. HANNAH: That is right.

4 MR. SIMON: What about the freedom of choice?

5 DR. HANNAH: He picked his plan in the first
6 place.

7 MR. SIMON: Is he stuck for life with it?

8 DR. HANNAH: Unless he has some very good
9 reason. I mean, the standard plan is a standard plan, whether
10 it is from A or B.

11 MR. WHITNEY: Let us clear this up.

12 THE CHAIRMAN: Maybe we had better follow our
13 regular policy here and let the one who is questioning complete
14 his questions first.

15 MR. NAYLOR: I think the point has been brought
16 out that it does seem that your proposal would seriously limit
17 freedom of choice and, possibly, it is not quite consistent
18 with the apparent intention of the Government to make this
19 standard plan universally available during the initial enroll-
20 ment period.

21 DR. HANNAH: I wouldn't make it prohibitive for
22 anyone else to take him.

23 MR. NAYLOR: No. But you are not requiring any
24 other carrier to take him?

25 DR. HANNAH: The only person that should be



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1 required to carry him is the person that had him previously,
2 unless somebody else wants to take them.

3 MR. NAYLOR: I am not entirely clear as to your
4 reasons for thinking that is necessary. Do you feel, from the
5 standpoint of your organization, that during the initial enroll-
6 ment period that there would be any great objection to it if
7 any resident could come to you even if he had a limited form
8 of coverage now with somebody else?

2 9 DR. HANNAH: I am not so much concerned with
10 the initial enrollment period. I would not be too worried
11 about that. But I am concerned with the possibility that some
12 time in the future, at a time when it is most convenient to the
13 carrier being able to shift the responsibility or the indivi-
14 dual being able to shift the responsibility and get a rate
15 that is to their own particular advantage. I wouldn't be too
16 concerned about the initial enrollment period.

17 I, frankly, do not think there will be too many
18 people who have been with A.M.S., for instance, that would
19 want to go anywhere else, or that have been with an insurance
20 company that would want to go anywhere else. I doubt if there
21 would be many of those.

22 But in the initial enrollment period, I wouldn't
23 object if we had to take them during that time, provided it is
24 limited.

25 MR. NAYLOR: I think that covers that point.

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1 Looking at paragraph 6, on page 4, you state there:

2 "A.M.S. is of the opinion that Bill 163
3 is so late in its appearance and so
4 inadequate in its concept that long before
5 it will be possible to have the legislation
6 set up and operating satisfactorily, every
7 resident in Ontario will have had the oppor-
8 tunity to enroll, irrespective of age or
9 health."

10 I do not quite understand that. I wonder how
11 you feel that the residents will be able to enroll? For
12 instance, is A.M.S. selling your coverage now to any indivi-
13 dual who wants to walk in and apply for it?

14 DR. HANNAH: Not quite that way; but that is not
15 the only way that it can be done. For instance, P.S.I. have
16 canvassed, I think it is, nine communities already on an open
17 enrollment basis. Windsor Medical Services have a continuous
18 opening, or a continuous open enrollment for the peoples of
19 Essex and Kent Counties.

20 Associated Medical Services, for instance, has
21 within the past year canvassed some 10,000 pensioners who
22 never had a plan - at least were retired before they took on
23 a group, from which they retired. And it is my opinion that
24 if this matter is left for as long as it will take to get
25 this Act through and get the machinery set up to operate it,



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1 that everybody will have had that opportunity and I am sure
2 that there are other people doing the same thing. For
3 instance, we all have seen the big...

4 MR. NAYLOR: Medical?

5 DR. HANNAH: ...Medical advertisement. So
6 that is why I say this statement.

7 MR. NAYLOR: I was aware that in certain
8 limited areas this was being done and in limited periods, by
9 Medical; but it would still seem that there, perhaps, would
10 be a large number of residents in the province that do not,
11 under present circumstances, have the right to buy individual
12 medical coverage regardless of their state of health.

13 DR. HANNAH: That is true at any one particular
14 time; but given time - and I am a great believer in doing
15 things progressively and systematically and within the limits
16 of our experience, rather than saying and hoping that we can
17 do tomorrow what can't be accomplished for the next five-ten
18 years. You can't do that, in my opinion, and still remain
19 solvent, and that is why I made this statement. I think it
20 would be much better to gradually bring these people in than
21 to have to go out and set up a mammoth organization or have
22 to take them on on a big campaign of advertising and enroll-
23 ment, and so on.

24 I think it would be much better to utilize the
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1 you will have, I say, in the long run, just about the same
2 results.

3 MR. NAYLOR: Thank you. That is all I have.

4 THE CHAIRMAN: Mr. Mulrooney?

5 MR. MULROONEY: My questions, Mr. Chairman,
6 have been put otherwise and answered and I have no questions
7 at this time.

8 MISS CARPENTER: I was wondering, in terms of
9 our discussion this morning, whether A.M.S. is paying the full
10 O.M.A. schedule for a doctor's fees or are they paying a
11 portion?

12 DR. HANNAH: We are paying the full practice in
13 general tariff of fees. We do not pay the specialist tariff.

14 MISS CARPENTER: People, then, who have A.M.S.
15 coverage pay their own specialist fee, if they need a
16 specialist?

17 DR. HANNAH: If they are charged for it.

18 MISS CARPENTER: Would they not be charged for
19 it if they have a specialist looking after them?

20 DR. HANNAH: I know of a great many specialists
21 who do not charge them.

22 MISS CARPENTER: How many people are enrolled in
23 the A.M.S. plan?

24 DR. HANNAH: Roughly 259,000 souls.

25 MR. WHITNEY: There are two minor things that



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20 who do not charge them.

21 MISS CARPENTER: How many people are enrolled

22 the A.M.S. plan?

23 DR. HANNAH: Roughly 250,000 souls.

24 MR. WHITNEY: There are two minor things that



1 occurred to me. In your own plan, do you have a statement of
2 health on the application? Do you secure a statement of health?

3 DR. HANNAH: On the individual coming in off
4 the street?

5 MR. WHITNEY: Yes.

6 DR. HANNAH: Yes, and it is a very strict one.

7 MR. WHITNEY: And do you rate the individual
8 according to the health conditions you find in the evidence
9 submitted?

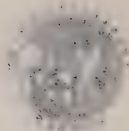
10 DR. HANNAH: No. We may place exclusions on
11 him for those conditions. However, after a period of five
12 years, they are eligible for anything that can be corrected
13 by surgery and, after a period of two years, they are entitled
14 to certain other benefits that might have been excluded.
15 There is a waiting period also on obstetrics when they come
16 in off the street, and certain other conditions.

17 MR. WHITNEY: With respect to the age of the
18 applicants, do you rate them whether they are 60 or 65?

19 DR. HANNAH: We will not take them over 55; but
20 we do not rate them prior to that.

21 MR. WHITNEY: Excuse me?

22 DR. HANNAH: We will not take them after the
23 age of 55, on the individual plan. In groups they can come
24 in and they can stay right through. But on the individual
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25 plan, we will not take them after the age 55. However, if



1 they belong to us for a period of five years prior to reaching
2 55, they can carry through to the grave.

3 MR. WHITNEY: Thank you.

4 THE CHAIRMAN: Does that apply to the ones who
5 are with you in groups, too?

6 DR. HANNAH: Yes, that is correct - any plan
7 that we have got. In the group, they do not have to belong
8 for the five years.

9 THE CHAIRMAN: I do not think anyone asked you
10 for a copy of your standard contract or contracts.

11 DR. HANNAH: For the extended contract?

12 THE CHAIRMAN: No - a copy of your contract form.

13 DR. HANNAH: No. Nobody has.

14 THE CHAIRMAN: If you wouldn't mind leaving it,
15 if you have one, or, if you do not, if you would send one to
16 the Secretary, I think it might be helpful.

17 MR. COULTER: I would like to know, Dr. Hannah,
18 how a person over the age of 65 gets into a group.

3 19 DR. HANNAH: For instance, a year ago this
20 winter - we have the railway contract for the Province of
21 Ontario - we knew that there was some 10,000 people living
22 who had retired from the railway prior to 1957, when we took
23 the contract on. Now, with the assistance of the railway we
24 wrote to every one of those retired individuals, giving them
25 an opportunity of enrolling. Now, I grant you that at the



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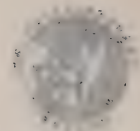


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2 but that is proposed to be remedied by this Act, in the first
3 instance. Now, this is reasonable enough if you have means of
4 distributing the costs, but it is not reasonable to allow
5 these people - and that is part of the reason for my answer
6 to Dr. Butt - it is not reasonable, in my opinion, to allow
7 an individual to stay out until he reaches 65 and then think
8 he can walk into anybody and get coverage because he thinks
9 he is going to have high expenses.

10 MR. COULTER: I have another question, if I may,
11 Mr. Chairman. Sometimes it has been feasible for people within
12 the boundaries of our country to insure themselves in many
13 ways, other than by insurance. In other words, putting money
14 in the bank and taking a chance on having a fire or sickness
15 or a car accident, or what-have-you. But it is also feasible
16 for a person to change his mind, whether his age be 35 or 65.

17 Now, the person that has never had any, other
18 than probably hospital coverage, wants medical coverage at 65
19 and has never been carried by any group and I believe that you
20 said that this person should be carried by his original group,
21 or that any group has the right to turn him down. If all
22 groups turn him down, where does he get coverage?

23 DR. HANNAH: No. I think we are talking at
24 cross-purposes. That is not what I said about the original
25 enrollment. I said everybody should have the opportunity of



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1 enrolling in the original instance.

2 MR. COULTER: I think they have this now.

3 DR. HANNAH: But they will have another oppor-
4 tunity when this opens; otherwise, you leave the thing wide
5 open to the individuals who want to stay out until they
6 have a bill in their hand, to get it paid.

7 MR. COULTER: What happens to this person if
8 he has chosen to stay out, for many reasons, and he is now 65?
9 Should all carriers have the right to turn him down?

10 DR. HANNAH: Not in the original instance.
11 But I think it would be fair enough, if you wish my opinion
12 on it - Mr. Chairman, may I give it?

13 THE CHAIRMAN: Certainly.

14 DR. HANNAH: I think it would be fair enough to
15 say to that individual who has, for whatever reason you like,
16 stayed out till he is 65, to say to him, "If you had belonged
17 to us for a certain period of time" - and it would take a
18 little working out to know what that would be - "you would have
19 contributed toward the reserves against the possibility of you
20 having heavy illness from 65 on and you, therefore, have to
21 pay into the jackpot the equivalent of what you would have
22 added to the reserve, so that you are not coming in on the
23 reserves of all the other people who have paid in for years
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1 MR. COULTER: I agree with this entirely.

2 DR. HANNAH: This, I think, would be a
3 reasonable proposition.

4 MR. COULTER: I agree. But at the same time I
5 can still see people arriving at the age of 65 without
6 coverage and I do not think we can say to them, if we are
7 going to run a provincial plan, "Well, we can't cover you."

8 DR. HANNAH: May I ask him a question, Mr.
9 Chairman? Would you say they have the right to stay out until
10 they had discovered they have something and then come in?

11 THE CHAIRMAN: We are getting into a debate now,
12 which we do not wish to do. Have you finished your questions,
13 Mr. Coulter?

14 MR. COULTER: Yes, Mr. Chairman.

15 THE CHAIRMAN: Dr. Galloway?

16 DR. GALLOWAY: A great deal of discussion has
17 been going on about an individual who has, prior to this, not
18 availed himself of this opportunity and now he has a condition
19 that needs to be repaired. Have you any way of estimating,
20 either numerically or percentage-wise, what number of people
21 we are talking about?

22 DR. HANNAH: No, I haven't. But I was raised
23 as Scottish Presbyterian and what is right is right and what
24 is wrong is wrong and I do not believe it is right for anybody
25 to be able to do that, whether it be one or a thousand or ten



MR. GOUTIER: I agree with this entirely.

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reasonable proposition.

MR. GOUTIER: I agree. But at the same time I

can still see people arriving at the age of 65 without

coverage and I do not think we can say to them, if we are

going to run a provincial plan, "Well, we can't cover you."

DR. HANNAH: May I ask him a question, Mr.

Chairman? Would you say they have the right to stay out until

they had discovered they have something and then come in?

THE CHAIRMAN: We are getting into a debate now

which we do not wish to do. Have you finished your question?

Mr. Goutier?

MR. GOUTIER: Yes, Mr. Chairman.

DR. HANNAH: Yes, Mr. Chairman.

DR. GALLAGHER: A great deal of discussion has

been going on about an individual who has, prior to this, not

availled himself of this opportunity and now he has a condition

that needs to be repaired. Have you any way of estimating,

how many people are in this category, and how many of them

we are talking about?

DR. HANNAH: No, I haven't. But I was raised

on the idea that if you are in a position where you are

in a position where you are in a position where you are

to be able to do that whether it be one or a thousand or ten



1 thousand.

2 DR. GALLOWAY: In a broad insurance plan it
3 would be fair?

4 DR. HANNAH: Mind you, we are taking care of
5 those people in the original instance; they are all having an
6 opportunity to enroll.

7 MR. SIMON: The last few winters there have
8 been several hundred thousand unemployed citizens in Toronto.
9 Supposing this plan is put into effect in the winter months
10 when we have hundreds of thousands unemployed, and they can't
11 buy insurance. Do you say that if they want to buy it a few
12 months later when they have a job that they have to pay more
13 for it? Is that fair?

14 DR. HANNAH: No. This will be looked after by
15 the subsidy that the Government promises to put up in this
16 situation under this Bill. Am I not right in that?

17 THE CHAIRMAN: It all depends upon the terms
18 that are set up according to how the subsidy would be paid.
19 That has not yet been established.

20 MR. SIMON: Dr. Hannah, coming to the point of
21 indigents and cases that the Government anticipates subsidizing
22 or supporting, would your organization be interested in sharing
23 this with other carriers or would you rather that they be taken
24 care of by one carrier? What are your views on that?

25 DR. HANNAH: I would not be averse to taking a

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care of by one carrier? What are your views on that?

DR. HANNAH: I would not be averse to taking a



1 share of them, but I believe it would be better for everybody
2 if they are handled under one situation. I can visualize so
3 many different situations arising that it would be very diffi-
4 cult to handle them if there were numerous carriers. I can
5 give you an illustration of what a difficulty it might be.

6 We have a certain group and, according to
7 union regulations, today they may belong to one pay category -
8 tomorrow they may belong to another one. I can visualize that
9 if this had to be distributed among a great many carriers,
10 there would be a great deal of difficulty in administering it;
11 whereas if you have one common carrier for this group, it
12 would be simple to administer.

13 THE CHAIRMAN: Are there any further questions
14 from members of the Enquiry? Do you wish to make any further
15 comments, Dr. Hannah?

16 DR. HANNAH: None, sir, except to thank you very
17 much.

18 THE CHAIRMAN: Is the delegation here from the
19 Ontario Federation of Agriculture?

20
21 SUBMISSION OF THE ONTARIO FEDERATION OF AGRICULTURE

22 Appearances: Cecil Belyea
23 C. Huffman
24 W. McCoig
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10 whereas if you have one common carrier for this group, it
11 would be simple to administer.

12 THE CHAIRMAN: Are there any further questions
13 from members of the Industry? Do you wish to make any further

14 DR. HANMER: None, sir, except to thank you very

15 THE CHAIRMAN: Is the delegation here from the
16 Ontario Federation of Agriculture?

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18 Wm. F. Davidson

19 THE CHAIRMAN: Members of the Industry have



1 received and studied the brief you submitted. In accordance
2 with the guide for participation in hearings that was mailed
3 to you, it will not be necessary for you to read your brief,
4 but you do have an opportunity to emphasize or enlarge upon
5 its conclusions or recommendations.

6 Members of the Enquiry may ask you questions on
7 the statements or recommendations submitted in your brief, but
8 you are not to be subjected to examination or cross-examination
9 by other persons.

10 It is not our intention to debate your sugges-
11 tions or recommendations, nor to state the views of this
12 Enquiry on them. Consequently, any opinions expressed in
13 questions asked or statements made by members of the Enquiry
14 are intended for clarification only.

15 As stated in the instructions, one person is to
16 act as your spokesman. However, if the spokesman feels that
17 another member is better qualified to answer a specific ques-
18 tion from a member of the Enquiry, the spokesman may receive
19 the Chair's permission to request the other member to answer.

20 The members of the press have requested a copy
21 of your brief, and if you have copies with you, perhaps you
22 will hand them to the members of the press at the conclusion
23 of your submission.

24 Would the gentleman who is to be your spokesman
25 please identify himself?

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Would the gentleman who is to be your spokesman please identify himself?



1 MR. BELYEA: Yes, sir. Cecil Belyea is my
2 name. I have with me Charles Huffman of Harrow, who is the
3 first Vice-President of the Ontario Federation of Agriculture.

4 4 On my right, Mr. Wilson McCoig, Manager of the Kent Co-Opera-
5 tive Medical Services, and also Mr. William Bradshaw, who is
6 Manager of the Lambton Medical Co-Operative Services.

7 THE CHAIRMAN: Will you proceed, please? Do you
8 wish to add anything to your brief?

9 MR. BELYEA: I think, so far as I am concerned,
10 this statement by the Federation of Agriculture represents
11 pretty well the limit of our investigations into the question
12 of health insurance. It is intended primarily to support the
13 brief presented this morning by the Co-Operative Medical
14 Services Federation. It includes some items from our stated
15 policy and the policy of the Canadian Federation of Agriculture,
16 of which the Ontario Federation of Agriculture is a member body,
17 concerning health insurance on the national scale and we felt
18 that some of this national policy had relevance to the Ontario
19 situation and that is why it was included.

20 THE CHAIRMAN: I think Mr. McCoig will confirm
21 that we did subject the members or representatives of the
22 Co-Operative Medical Services to quite a number of questions
23 and undoubtedly there will be some questions that the members
24 of the Enquiry would like to ask of you as well.

25 Miss McArthur?

MR. BELYEA: Yes, sir. Geoff Belyea is my

name. I have with me Charles Hufman of Harrow, who is the

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that we did subject the members or representatives of the

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and undoubtedly there will be some questions that the members

of the Board may like to ask of you as well.



1 MISS McARTHUR: Mr. Chairman, because of clari-
2 fication this morning I have only one. That is in relation to
3 page 4, item (g) in which you enunciate the principle which
4 you would like accepted and that is that the provision of
5 psychiatric services should be essentially provided by means
6 of public services rather than through private practice. I
7 would be interested in hearing the basis or the reasons on
8 which such a principle has been formulated.

9 MR. BELYEA: I am afraid I am not prepared to
10 answer that question. This is a part of the National Canadian
11 Federation policy and I am afraid that I am not in a position
12 to answer that. I do not know if Mr. Huffman can or any of
13 the others.

14 MISS McARTHUR: We may be able to find the
15 answer from some other source, then. It was interesting that
16 it was set down there as a principle.

17 MR. COULTER: Can you have that answer sent in
18 to us?

19 MR. BELYEA: Yes.

20 DR. GALLOWAY: It seems to be in keeping, on
21 page 3 at the very bottom of the page, with No. (b), in which
22 it is suggested that there be a compulsory national medical
23 health insurance program.

24 MR. COULTER: I haven't anything in particular
25 to ask, other than I think in one particular case - I do not



MISS MCARTHUR: Mr. Chairman, because of clarification this morning I have only one. That is in relation to page 4, item (e) in which you enunciate the principle which you would like accepted and that is that the provision of psychiatric services should be essentially provided by means of public services rather than through private practice. I would be interested in hearing the basis or the reasons on which such a principle has been formulated.

MR. BELYEA: I am afraid I am not prepared to answer that question. This is a part of the National Canadian Federation policy and I am afraid that I am not in a position to answer that. I do not know if Mr. Hoffman can or any of the others.

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MR. GOUTIER: I haven't anything in particular to ask, other than I think in one particular case - I do not



1 know whether it is in this brief or the Medical - where they
2 ask that particular attention be paid to farmers who are not
3 covered by Workmen's Compensation, particularly in the case of
4 broken legs or loss of limbs. Can you explain this problem a
5 little further?

6 MR. BELYEA: Farmers ordinarily, Mr. Coulter,
7 are not covered by Workmen's Compensation. Only a very small
8 percentage of farmers would be. Consequently, the loss of a
9 limb or impairment, physical impairment, means a great deal to
10 the farmer who, because of the labour situation and the depen-
11 dence on the farmer himself as the manager and labourer in the
12 farm situation, means that the farm business is seriously
13 disadvantaged, the farm family is disadvantaged and certainly
14 the farmer himself, because when he is impaired then the
15 income virtually ceases on the farm and we feel that he has
16 not had the same advantages with respect to securing coverage
17 as urban workers have.

18 The farmers' rates, incidentally, are very high,
19 probably because of his hazardous occupation, so that most
20 farmers have not found it possible or - I guess possible would
21 be the word - to be looked after under the Workmen's Compensa-
22 tion Act.

23 MR. COULTER: Thank you.

24 THE CHAIRMAN: Does that complete your questions,
25 Mr. Coulter?



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tion Act.

THE CHAIRMAN: Does that complete your question?



1 MR. COULTER: I was just wondering if they had
2 any further ideas on Section 11 of their brief. At the top of
3 page 6 you talk of "The formation of a body to be known as
4 Medical Carriers Incorporated ---" This morning the Co-Opera-
5 Medical Services suggested that, in their opinion, they would
6 rather see this set up under the Department of Insurance,
7 rather than the Medical Carriers. Does the Federation have
8 any further views along this line?

9 MR. McCOIG: Mr. Chairman, I believe this was
10 covered this morning. We feel, as stated here, that in Bill
11 163 the Medical Carriers Incorporated duties are not very
12 clearly spelled out. My personal opinion is that it leaves
13 quite a bit more information needed before you could actually
14 assess this thing. All the details are not appearing that we
15 would hope to have seen right at the start.

16 MR. BELYEA: May I say this: that the Federation
17 of Agriculture has examined Bill 163 and, like Mr. McCoig,
18 feels that the delineation of the actual functions of the
19 Board and its powers is not clear enough; at least, it is not
20 clear enough to satisfy us as to what use will be made of it
21 in all details.

22 Perhaps the Ontario Federation of Agriculture
23 would not feel as strongly about this as the Co-Operative
24 Medical Services Federation; yet, we feel that until these
25 powers and the functions of the proposed Board are laid out



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1 more clearly, then we would have to question it. We have some
2 questions, I think, about the multiplicity of government
3 boards. I think that perhaps this number of boards is growing
4 all the time and if the Department of Insurance can do the
5 same job, perhaps a division of the Department of Insurance,
6 then we wonder if there is a need for this other board.

7 MR. COULTER: Can I ask a question of the
8 Co-Operative? In the case of the M.C.I. not reaching an
9 agreement, then it goes to arbitration and the arbitration
10 board is set up of two from the medical carriers, and a judge
11 presumably representing the public. Mr. Simon's concern was
12 would the judge, sitting as the Chairman of the arbitration,
13 represent the public as the public should be represented?
14 What would be your thought here?

15 Or should there be somebody else from the
16 public on this arbitration board?

17 MR. BELYEA: I do not think the Ontario Federa-
18 tion of Agriculture would have an opinion about that.

19 MR. COULTER: That is all, thank you.

20 THE CHAIRMAN: Mr. Major?

21 MR. MAJOR: Mr. Belyea, on page 3, you talk
22 about "co-operative principles." Can you enunciate what the
23 co-operative principles are?

24 MR. BELYEA: The co-operative principles?

25 MR. MAJOR: Yes.



more clearly, then we would have to question it. We have some questions, I think, about the multiplicity of government boards. I think that perhaps this number of boards is growing all the time and if the Department of Insurance can do the same job, perhaps a division of the Department of Insurance, then we wonder if there is a need for this other board.

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Or should there be somebody else from the public on this arbitration board?

MR. BELYEA: I do not think the Ontario Federation of Agriculture would have an opinion about that.

MR. GOULTER: That is all, thank you.

MR. MAYOR: Mr. Belyea, on page 3, you talk about "co-operative principles." Can you enunciate what the co-operative principles are?



1 MR. BELYEA: I might preface my statement by
2 saying that we believe that these co-operative principles
3 fit very neatly into what we call, loosely, the free-enter-
4 prise system. We believe co-operatives are part of the free-
5 enterprise system, with a difference from ordinary concepts,
6 that the co-operative action represents a group of people
7 attempting to better themselves economically and socially,
8 through collective action, usually in the economic field.
9 It is based on the principle that the services that people
10 need and are willing to pay for can be purchased more nearly
11 at cost by people working together as a group. This represents
12 a saving and it is considered to be beneficial that such a
13 saving should be made. Also, as we have suggested here,
14 because the co-operative business is ordinarily run by those
15 - run and owned by those who make use of the co-operative,
16 then the members' of the co-operative's needs are reflected
17 more nearly by the policies of the co-operative.

18 It is a case of economic democracy in action,
19 we believe.

20 MR. MAJOR: Does this endeavour to exclude
21 profit?

22 MR. BELYEA: Not necessarily, no.

23 MR. MAJOR: Thank you, Mr. Belyea. On the
24 same page, you state - this is at the end of paragraph 7,
25 prior to sub-section (a) - "at a premium that the lowest

MR. BELVERA: I might preface my statement by

saying that we believe that these co-operative principles

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MR. MAJOR: Thank you, Mr. Belver. On the

same page, you state - this is at the end of paragraph 7,

prior to sub-section (a) - "at a premium that the lowest



1 income group can reasonably afford." Do you know what that
2 premium might be, in dollars and cents?

3 MR. BELYEA: I have no idea, sir.

4 MR. MAJOR: And the same thing would apply to
5 the first two sentences or lines in paragraph (c) at the top
6 of page 4, where you say:

7 "That public medical insurance be imple-
8 mented on a basis that is contributory to
9 a reasonable degree..."

10 This is a little bit abstract, but can you
11 define this "reasonable degree"?

12 MR. BELYEA: From my understanding of it, sir,
13 not all people are able, financially, to afford insurance.
14 Farmers, as you know, are capitalists - they are free enter-
15 prisers to the nth degree and this sort of idea suits farmers.
16 I think farmers like to pay their way and, to a limited extent,
17 they feel - well, let us not limit it in any way - they feel
18 that there are people in society who are unable to pay their
19 way and these people should be looked after.

20 MR. MAJOR: Is this "reasonable degree," then,
21 that degree that is set forth in Bill 163, which says, in
22 essence, that government may purchase for the indigents and
23 the marginal income people medical insurance? Is this the
24 reasonable degree, in your opinion?

25 MR. BELYEA: Yes, I think it is.



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MR. BELLEA: Yes, I think it is.



1 MR. MAJOR: Thank you. Now, the fees and
2 psychiatric services, we have touched on that.

3 MR. BELYEA: May I have Mr. McCoig speak to
4 that?

5 MR. McCOIG: Mr. Chairman, in attempting to
6 partially answer Miss McArthur's question, I believe you
7 remember - you have notes of this last week in Windsor -
8 Windsor Medical made a statement, to the best of my knowledge,
9 that was something like this; that they felt that when we had
10 psychiatric services, there either had to be a limit on it or
11 through a public body.

12 With my limited knowledge of bills coming in
13 in increasing numbers, and looking after these bills, I cannot
14 see this put through the insurance carriers. It looks to me
15 as though it will run away with itself, as far as costs is
16 concerned. This is my personal opinion, from a limited
17 experience in an increasing number of bills which has started
18 to come in.

19 MISS McARTHUR: Your concern was the implemen-
20 tation of the Bill, and the control of cost until one had
21 experience?

22 MR. McCOIG: Exactly.

23 MR. MAJOR: On page 5, the last lines of para-
24 graph 9, it says that:

25 "---all parties are prepared to make some

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graph 9, it says that:

"---all parties are prepared to make some



1 small sacrifices ---"

2 What sacrifices is the citizen going to have to
3 make in this set-up?

4 MR. BELYEA: The citizen?

5 MR. MAJOR: Or the farmer, or however you want
6 to put it.

7 MR. BELYEA: Well, I suppose there may be some
8 people with religious scruples about insurance. If we're
9 going to make this compulsory, it has to be compulsory. I
10 don't know how you gauge the size of such a sacrifice.

11 MR. MAJOR: This is not compulsory on the
12 citizen. He doesn't have to buy this insurance.

13 MR. BELYEA: Doesn't insurance have to be
14 carried on his behalf?

15 MR. MAJOR: No; the carrier has to provide it
16 if the citizen requests it, but the citizen doesn't have to
17 buy it.

18 MR. BELYEA: Oh, I see.

19 MR. MAJOR: He's free. There's no compulsion
20 on the citizen. Now, my question is, and I've asked this
21 of other groups that have stated that everybody has been
22 willing to make a sacrifice -- I want to know what sacrifice
23 the citizen is going to have to make under Bill 163.

24 MR. BELYEA: I think, sir, that we were not
25 thinking of it from the standpoint of the sacrifice that the

small sacrifices ---

What sacrifices is the citizen going to have to

make in this set-up?

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the citizen is going to have to make under Bill 163.

MR. BELLEA: I think, sir, that we were not



1 citizen might have to make specifically. We were concerned
2 with the kind of arrangements, or compromises that might have
3 to be reached between carriers and physicians.

4 MR. MAJOR: Well, I'm just taking your words:

5 "---the medical profession and consumers
6 arising out of a government health plan
7 cannot be worked out provided all parties
8 are prepared to make some small sacrifices
9 for the sake of the public good."

10 THE CHAIRMAN: Where is this, Mr. Major?

11 MR. MAJOR: On page 5, the last two lines in
12 paragraph 9.

13 MR. SIMON: Would you be prepared to say that
14 we would have to pay more taxes for it? Is that the sacrifice
15 we would have to make?

16 MR. BELYEA: That's right; but a reasonable one.

17 MR. WHITNEY: You are probably thinking also,
18 are you, that you would probably have to revise the plans in
19 your own groups to get into line?

20 MR. BELYEA: Yes.

21 MR. MAJOR: "---the financial integrity of all
22 Ontario citizens." I guess we can leave that go by.

23 DR. HAMILTON: Mr. Belyea, at the bottom of page
24 5 there is a statement that the rural community is typically
25 lacking in facilities for treatment.



1 citizen might have to make specifically. We were concerned
2 to be reached-between carriers and physicians.

MR. MAJOR: Well, I'm just taking your words:

"---the medical profession and consumers
arising out of a government health plan
cannot be worked out provided all parties
are prepared to make some small sacrifices
for the sake of the public good."

THE CHAIRMAN: Where is this, Mr. Major?

MR. MAJOR: On page 5, the last two lines in

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DR. HAMILTON: Mr. Belyea, at the bottom of page

5 there is a statement that the rural community is typically

lacking in facilities for treatment.



1 I wonder if you could expand on that a little,
2 and tell me what are the principle deficiencies in terms of
3 medical care in the rural area?

4 MR. BELYEA: Perhaps I could give you an example
5 which has been mentioned to me, Dr. Hamilton. There is in this
6 case -- it won't be necessary to mention names, of course --
7 an individual, a father had a child who required physiothera-
8 peutic treatment, and also prosthesis, and because this man
9 lived something like 70 or 80 miles from the City of London,
10 which was the nearest place where this treatment could be had,
11 he was put to considerable expense by the fact of having to
12 travel to London twice weekly, and perhaps ignoring his busi-
13 ness of getting an income. This made it considerably diffi-
14 cult, and it lasted over a considerable period of time.

15 DR. HAMILTON: Is there difficulty in obtaining
16 services from a doctor in the rural areas?

17 MR. BELYEA: Would you care to say something,
18 Mr. Huffman?

19 MR. HUFFMAN: I would like to answer yes there
20 is. The profession, it seems to me, doesn't like to locate in
21 small towns. This is one of the rather bad features today.
22 They prefer to locate in the city, and it's quite difficult in
23 some rural town areas to get the medical profession to locate
24 there.

25 DR. HAMILTON: In areas where the medical



I wonder if you could expand on that a little.

medical care in the rural areas?

MR. BELYEA: Perhaps I could give you an example

where I have been practicing for some time. There is a town

called -- it is called -- I don't know, it is called --

an individual, a father had a child who required physiother-

apeutic treatment, and also physiotherapy, and physiotherapy and

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in the small towns, and I have been in the small towns.

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there.

DR. HAMILTON: In areas where the medical



1 co-operatives are located?

2 MR. HUFFMAN: Yes, I would say so.

3 DR. HAMILTON: That some of the insured people
4 have difficulty in obtaining the services that they are
5 insured for. Is this true?

6 MR. HUFFMAN: I would have to say in these
7 terms that there is not sufficient professional doctors in
8 the towns, and therefore, by the means of not having enough
9 doctors located in these rural towns.

10 DR. HAMILTON: But you have no specific informa-
11 tion?

12 MR. HUFFMAN: No, I have no specific information.

13 MISS McARTHUR: On page 6, in paragraph 12, I
14 was wondering if this use of the word "discrimination" referred
15 to the brief we received this morning, and related to such
16 things as age, and developing physical conditions I think were
17 the two quoted in the brief this morning.

18 Are those the factors you are suggesting here,
19 or did you have other ideas in mind when you spoke of discrimi-
20 nation?

21 MR. BELYEA: We think, madam, that what we have
22 in mind is that no particular carrier should be given any
23 special consideration by any ---

24 MISS McARTHUR: You were thinking in terms of
25 the carrier, rather than the coverage, when you were expressing



co-operatives are located?

MR. HUFFMAN: Yes, I would say so.

DR. HAMILTON: That some of the insured people

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MISS McARTHUR: You were thinking in terms of



1 this?

2 MR. BELYEA: Yes.

3 DR. GALLOWAY: Mr. Chairman, the only question I
4 have is in effect you made the statement that there are insuffi-
5 cient doctors in the small towns, and this is likely true, and
6 it's partly financial conditions play some part in this.

7 I was very interested in the brief presented
8 this morning, in which your Federation of Co-Operatives are
9 making funds available to educate medical students. Have you
10 taken any steps in any of your co-operatives in regard to
11 subsidizing a physician to locate in any of these towns which
12 you say are insufficiently doctored?

13 MR. BRADSHAW: Mr. Chairman, in one town that I
14 know of the Chamber of Commerce in this small town did raise
15 an amount of money, and provided a place for a doctor, in order
16 to get him to come into this town, and he has stayed there a
17 year, and I understand he's leaving, but there's sufficient
18 business in that area to keep a doctor, I think, quite busy,
19 but because of the shortage of doctors it seems difficult to
20 get one and to hold him there.

21 DR. GALLOWAY: Maybe the subsidy isn't high
22 enough?

23 MR. McCOIG: It isn't, Mr. Chairman, exactly the
24 scarcity of doctors, in my opinion, and I lived for the major
25 part of my life quite close to Blenheim, and I now live in



MR. PRYOR: Yes.

DR. GALLOWAY: Mr. Chairman, the only question

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enough?



1 Chatham. It's some reluctance on the part of the profession
2 to make country calls.

3 Also, in Blenheim, and to my mind it's quite a
4 serious situation, these doctors travel from Blenheim to
5 Chatham, about 14 miles, to see their patients in the hospital
6 in Chatham. We had quite a serious accident in Blenheim. A
7 man was at the top of a silo, and got his arm caught. This
8 necessitated him being rushed to Chatham.

9 It's my own personal opinion that this group of
10 doctors are banded together in an association, and I wonder
11 why they couldn't work out something in order that one doctor,
12 at least, would remain in Blenheim in the forenoons, and make
13 his calls in the afternoon in Chatham, because it's quite
14 serious in some of these things, where there's no doctor
15 available for the first half of the day.

16 DR. GALLOWAY: I have nothing to comment on,
17 sir, except, have you ever suggested this to the doctors?

18 MR. McCOIG: Well, we feel that we would have no
19 right to suggest this, only on a personal basis. This is my
20 own opinion.

21 MR. SIMON: Mr. Belyea, in (b) at the bottom of
22 page 3, and (c) on the top of page 4, you say:

23 "That the Federal Government adopt as a
24 policy the implementation of a national
25 compulsory medical care insurance program



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19 right to suggest this, only on a personal basis. This is my
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22 MR. SIMON: Mr. Belyea, in (b) at the bottom of
23 page 3, and (c) on the top of page 4, you say:
24 "That the Federal Government adopt as a
25 policy the implementation of a national
26 compulsory medical care insurance program"



1 to be carried out in co-operation with the
2 provinces."

3 And then you carry on to say:

4 "That public medical insurance be imple-
5 mented on a basis that is contributory to
6 a reasonable degree ---" and so on.

7 Am I right in my thinking that you are advoca-
8 ting something that is similar to the Ontario Hospital, or the
9 Federal Hospital Insurance Plan, that is contributed to by the
10 Federal Government and the Provincial Governments, and the
11 individual citizen? Is that what you have in mind?

12 MR. BELYEA: Yes.

13 MISS CARPENTER: On page 3, further to these
14 co-operative and democratic principles, I was wondering if you
15 have any suggestions as to how we could build into Bill 163
16 citizens' participation to ensure this democratic control?

17 MR. BELYEA: I think that so far as the O.F.A.
18 is concerned, madam, what we ask the Government to do prior
19 to the legislation being brought forward is that the Government,
20 as we've said here, consider a co-operative way, so that I
21 don't know whether the Government has done that to any extent
22 or not.

23 MISS CARPENTER: You haven't got a specific
24 suggestion in the terms of Bill 163?

25 MR. BELYEA: No, unless either of the gentlemen



1 here has.

2 MISS CARPENTER: You just ask that this principle
3 be looked at by us?

4 MR. BELYEA: Yes.

5 MR. BRADSHAW: The co-operative principle, Mr.
6 Chairman, is one vote for one member, and this is regardless
7 of the number of shares they hold in any organization.

8 We feel that the Medical Carriers Incorporated,
9 as it is set out in Bill 163, provides for voting power as
10 related to a number of persons covered, I believe, and this
11 is contrary to co-op principles.

12 The principles laid down in Roachdale's
13 Principles of Co-Operatives stand for one vote for one member,
14 regardless of the size of the holdings of that member.

15 We would think more highly of Medical Carriers
16 Incorporated if it had that co-op principle in it.

17 THE CHAIRMAN: Mr. Belyea, I think that the
18 questions which have been asked by members of the Enquiry
19 indicate that they would be pleased to have more specifics,
20 and fewer generalities, possibly, than there are in the brief,
21 so that if you feel inclined to be a little bit more specific
22 in some of these things, and either submit your thoughts in
23 the form of proposed changes that might be made in the wording
24 of the Bill, or in any other way that is more specific, why,
25 it would be in order for you to add that as a supplement to



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indicate that they would be pleased to have more specifics,

so that if you feel inclined to be a little bit more specific

in some of these things, and either submit your thoughts in

the form of proposed changes that might be made in the wording

of the Bill or in any other way that is suggested to you

it would be all right for you to do so.



1 your brief.

2 We have extended similar privileges to others,
3 and it would be quite satisfactory for you to do that, not
4 with the thought in mind that you would necessarily be called
5 back again for a discussion of them.

6 Are there any other questions from members of
7 the Enquiry?

8 DR. BUTT: This is not a question. I would just
9 suggest that you couldn't ask the medical profession, but I
10 think you could ask the Kent County Medical Society about your
11 particular problem with regard to Blenheim, and having somebody
12 down there.

13 They would at least give it consideration. I'm
14 sure of that.

15 MR. McCOIG: You will remember, Dr. Butt, that
16 we did have a favourable comment last week in Windsor from
17 Kent Medical Society.

18 THE CHAIRMAN: There are no further questions.
19 Do you have any further comments, Mr. Belyea?

20 MR. BELYEA: No, sir.

21 THE CHAIRMAN: Thank you. Is the delegation here
22 from the School of Hygiene of the University of Toronto?

23

24

25



1. Your Honor.
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3. and it would be quite satisfactory for you to do that, not
4. only the members of the staff but also the members of the
5. back again for a discussion of them.
6. Are there any other questions from members of
7. the Faculty?
8. DR. BUTT: This is not a question. I would like
9. suggest that you couldn't ask the medical profession, but I
10. think you would like to know what the medical profession
11. has to say about the question of the medical profession.
12. down there.
13. They would at least give it consideration. I
14. sure of that.
15. MR. McGOIG: You will remember, Dr. Butt, that
16. the medical profession has a very high regard for the
17. medical profession.
18. THE CHAIRMAN: There are no further questions.
19. Do you have any further comments, Mr. Belyea?
20. MR. BELYEA: No, sir.
21. THE CHAIRMAN: Thank you. Is the delegation here
22. from the School of Hygiene of the University of Toronto?
23.
24.
25.



1 SUBMISSION OF STAFF MEMBERS, SCHOOL OF HYGIENE,

2 UNIVERSITY OF TORONTO

3 Appearances: Dr. A.J. Rhodes
4 Dr. F.B. Roth
5 Dr. W. Harding le Riche

6 THE CHAIRMAN: Gentlemen, were you here when we
7 read the instructions to the other delegation?

8 DR. RHODES: Yes, sir. I am Director of the
9 School of Hygiene; Dr. le Riche is head of the Department of
10 Epidemiology and Biometrics at the School of Hygiene; and Dr.
11 Roth is the head of the Department of Hospital Administration
12 and Professor of Medical Care at the School.

13 THE CHAIRMAN: Will you carry on then, please?

14 DR. RHODES: If it's agreeable to you, sir, I
15 would just like to add a few words, and perhaps for the sake
16 of about five minutes, in explanation of the brief that was
17 submitted to you.

18 We, first of all, I think, sir, and members of
19 the Enquiry, would like to emphasize that this general field
20 of medical care administration is an area of special interest
21 to university schools in public health, of which there are
22 about 14 in North America, two in Canada.

23 We would like, therefore, to make a few points
24 generally related mainly to principle, and not to detail, of
25 insurance schemes.

First a comment, sir, if I might, on the



PROCEEDINGS OF THE BOARD OF GOVERNORS

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THE CHAIRMAN: Gentlemen, were you here when

read the instructions to the other delegation?

DR. RHODES: Yes, sir. I am Director of the

Department of Pathology, and I am also Director of the
Department of Bacteriology and Immunology, and I am also
Director of the Department of Medical Care at the School.

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THE CHAIRMAN: Will you carry on then, please?

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generally related mainly to principle, and not to detail, of

First a comment, sir, if I might, on the



1 purposes of Bill 163. At first sight, when one opens the
2 cover of the Bill, one finds it is stated that the purpose of
3 the Bill is "To make it possible for all residents of Ontario
4 to obtain protection against the cost of medical and surgical
5 care and services." However, it would appear, and were
6 certainly in full agreement with this, that the true purpose
7 is more far-reaching, and more ambitious, and for that we have
8 to look at the advertisement which appeared in the newspaper
9 calling for briefs to be presented to you.

10 In this advertisement there are two particular
11 phrases, which we think bear a good deal of importance. The
12 first of these would be "Having regard to the maintenance of
13 the physical and material well-being of the people of Ontario."
14 That's one telling phrase.

15 The second one, "And the social, economic and
16 health benefits to be achieved through the establishment and
17 operation of a feasible medical services insurance program."

18 Mr. Chairman, it seems to us that by the use of
19 these expressions it is assumed that the health and well-being
20 of the people of Ontario will, in fact, be enhanced and
21 improved by a program designed to provide only a portion of
22 the health services that they require. This assumption - and
23 it is an assumption - may very well be justified on a long-term
24 basis.

25 However, we feel we ought to point out that a



the Bill is "To make it possible for all residents of Ontario to obtain protection against the cost of medical and surgical care and services." However, it would appear, and were certainly in full agreement with this, that the true purpose is more far-reaching, and more ambitious, and for that we have to look at the advertisement which appeared in the newspaper calling for briefs to be presented to you.

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The second one, "And the social, economic and operation of a feasible medical services insurance program." Mr. Chairman, it seems to us that by the use of these expressions it is assumed that the health and well-being of the people of Ontario will, in fact, be enhanced and improved by a system of medical services insurance.

However, we feel we ought to point out that a



1 specific scheme such as the one outlined in Bill 163 will
2 almost certainly, at first, at any rate, aggravate some of the
3 present problems in the delivery of personal health services
4 to the people of Ontario.

5 Some of the problems that may well be aggra-
6 vated are the shortage of physicians in some parts of the
7 province; the shortage of nurses in almost all parts of the
8 province; and the potential, if not actual, inadequacies in
9 many of the supporting facilities that make it possible for
10 a physician to render service to a patient.

11 I refer particularly to hospital, laboratory
12 and radiological services, physiotherapy and other rehabilita-
13 tive services; home care services, and special services for
14 the elderly.

15 We would like to emphasize, I think, that the
16 physical provision of these new health facilities, and the
17 strengthening of existing facilities, is not the responsibility
18 of the insurance companies, the physician-sponsored prepaid
19 plans, or any other carriers, but is indeed the responsibility
20 of individual local communities in Ontario. The general
21 principle we're trying to make out by this is that in
22 this general area of provision of medical services no program
23 can be viewed purely as an entity in itself. Inevitably, any
24 one program has an impact on and is influenced by other programs.

25 It's highly desirable, therefore, we feel, that



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1 some means should be found to ensure in this province a measure
2 of co-ordination between the five major components of health
3 services. I refer, of course, to the five components: the
4 services of physicians; the services of nurses and other
5 skilled personnel; hospital services; the services rendered by
6 officials of departments of public health, and public health
7 units; and, finally, the services rendered by voluntary health
8 agencies.

9 Bearing in mind, Mr. Chairman, the program that
10 you are considering at the moment, a program which we believe
11 is supposed to lead to an improvement in the social, economic
12 and health status of the nation, we have two aspects of
13 interest to our School.

14 The first is prevention, and we would like to
15 suggest that permanent and enduring improvement in health can
16 come about only by the widespread use of preventive measures.

17 Second, the fact that a program of this nature
18 must be based on an adequate statistical service.

19 If I might just add a word on prevention. The
20 major physical disease problems of today -- and we're not
21 dealing with mental disease -- are heart disease, cancer,
22 rheumatic and arthritic disease, and they will have to be
23 tackled by essentially the same type of techniques as have
24 proved so successful in reducing the incidence of many infec-
25 tious diseases. Particularly the technique of case-finding,



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1 which is a technical term for the early recognition of disease
2 before the extensive use of medical services is called for.

3 We believe that encouragement should be given
4 to the active seeking-out of disease in the earlier stages.

5 Now, in some instances this will require
6 organized programs, often called mass-screening programs of
7 sections of the population, looking for specific abnormalities
8 that can be quite easily tested for, for example, by chest
9 x-rays, test of blood, urine, blood pressures, eyes and ears,
10 and other comparatively straightforward tests.

11 Persons who are found to be abnormal in these
12 mass-screening programs would then be referred to their
13 personal physician.

14 We would suggest that encouragement should be
15 given to any agencies who may appear before you who are
16 prepared and equipped to undertake this type of work.

17 We would feel that at the moment, and as experts
18 in preventive methods we have to admit this with great reluc-
19 tance, we don't believe that periodic health examinations by
20 physicians of apparently healthy people are generally feasible.
21 At the moment we feel it would be largely a waste of valuable
22 medical time.

23 Our second major area of concern is in the
24 field of health statistics, and we say in the brief that we
25 feel there should be established a central statistical agency



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1 for the collection of data about services rendered by physi-
2 cians under approved insurance plans covered by the terms of
3 Bill 163, and this would be irrespective of whether the fees
4 concerned are paid by the patient or by the Government on the
5 terms of Schedule C, or another means whereby the Government
6 would assist, or by the patient.

7 The same agency, we feel, must also analyze data,
8 because there's little point in collecting masses of figures
9 unless they are analyzed.

10 We also feel this agency should have a third
11 function, to make available grants on a project basis to the
12 university staff and other people who are competent and
13 interested in studying certain specific aspects of the program.

14 We believe furthermore that this agency should
15 submit an annual report to the Legislature, through the
16 Minister of Health.

17 We would urge that the Bill or regulations
18 made thereunder specify that all carriers provide data to this
19 central statistical agency. We believe that it is only by the
20 collection and analysis of data that the program can be
21 assessed; for example, as to whether it is succeeding or
22 failing to provide social, economic and health benefits, as
23 the purpose of the Bill appears to be.

24 Finally, if we might make a somewhat specific
25 comment on financing, we're most impressed with the concept



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concerned are paid by the patient or by the Government on the
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unless they are analyzed.

We also feel this agency should have a third
function, to make available grants on a project basis to the
university staff and other people who are competent and
interested in studying certain specific aspects of the program.
We believe furthermore that this agency should
submit an annual report to the Legislature, through the

Minister of Health.

We would urge that the Bill or regulations
made thereunder specify that all carriers provide data to the
central statistical agency. We believe that it is only by the
collection and analysis of data that the program can be
assessed; for example, as to whether it is succeeding or
failing to provide social, economic and health benefits, as
the purpose of the Bill appears to be.

Finally, if we might make a somewhat specific



1 that operates in the Netherlands, where a somewhat similar
2 type of program is in force. All the health insurers make a
3 contribution to a central fund. This is called the Preventive
4 or Prophylaxis Fund, which is used to support preventive medi-
5 cine.

4 6 The money is used in a wide way, and at the
7 back of our brief we have set out some representative ways in
8 which they are spending the money. It includes, for example,
9 collection of data, analysis of data, and various research
10 programs, teaching programs in one of the universities in
11 Holland, and it is very definitely a service function through
12 voluntary health agencies.

13 We would support a somewhat similar philosophy
14 for Ontario. We realize that large sums of money inevitably
15 will be spent on curative medicine, and no doubt a lot of this
16 money will be profitably spent, yet our final words as a
17 group interested in preventive medicine would be to say that
18 in the long run it's to preventive measures that we have to
19 look for permanent benefits, and not to curative medicine.

20 MRS. AYLEN: Dr. Rhodes, at the bottom of page 2,
21 your suggestion that a 1% levy be made on a policy towards
22 research -- I was very interested in this, and it immediately
23 came to my mind, all the different voluntary programs that are
24 now being carried out in the province.

25 Would this be over and above the voluntary



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MRS. AYLMER: Dr. Rhodes, at the bottom of page your suggestion that a 1% levy be made on a policy towards research -- I was very interested in this, and in immediately came to my mind, all the different voluntary programs that are now being carried out in the province.



1 provisions, or would it be a substitute?

2 DR. RHODES: I'm not sure, madam, that I under-
3 stand the significance. We certainly feel if you were to
4 recommend that money were to be set aside, that some of it
5 should be used to support voluntary agencies already operating.

6 MRS. AYLEN: Perhaps I'm very ignorant in this
7 field. We're frequently asked to give to various foundations,
8 the Heart Foundation, and the Arthritic Association, but I
9 mean, they are voluntary contributions. Do you agree to that?

10 DR. RHODES: Oh, yes.

11 MRS. AYLEN: Well, are you suggesting that they
12 are inadequate?

13 DR. RHODES: Oh, no. The very reverse, madam.
14 I've been severely misunderstood. No, we feel if money is
15 collected on a compulsory basis from the carriers, a certain
16 percentage of their intake, then a sum of this could very well
17 be distributed, and usefully distributed through voluntary
18 agencies which are now doing in many cases excellent work.

19 MRS. AYLEN: What disease that is prevalent in
20 Ontario is not subject to research?

21 DR. RHODES: I think there is certainly no
22 disease in which more research could not be carried out.

23 MRS. AYLEN: You are just thinking of augmenting
24 it?

25 DR. RHODES: I don't think there's any field



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1 that's completely neglected. I think perhaps the whole field
2 of preventive medicine is one that has not, perhaps, received
3 as much attention as it should.

4 DR. GALLOWAY: I think what Dr. Rhodes means is
5 that this sentence must draw into context central research and
6 statistical agencies, and it's primarily in relation to statis-
7 tical research that you make this suggestion?

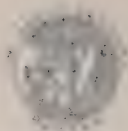
8 DR. RHODES: Yes, sir. We feel that if this
9 money is collected the number one use to which it is put is
10 to establish a first-class statistical agency. This might take
11 all the funds available. However, if funds were available over
12 and above what it takes to run the statistical agency, then
13 they should be put to the purpose for which the Dutch use
14 their money, which is collected in a similar way.

15 MRS. AYLEN: There's a program instituted in the
16 Hospital Association in connection with the Ontario Medical
17 Association on processing data.

18 Would that be a sort of a springboard for a
19 larger organization?

20 DR. le RICHE: That's a start in the right
21 direction, but we would like to see, Mr. Chairman, that more
22 of this work should be encouraged, but all of these things
23 aren't run with one objective in view.

24 I mean there's no co-ordination. It's a
25 horrible word. There are a lot of these scattered efforts in



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1 Ontario, and we think there should be more co-ordination. We
2 think there might be some overlapping of effort, because one
3 lot of people don't necessarily know what the others are doing,
4 and we feel that a great deal of this work should be run in one
5 agency preferably, or at least one agency should know what all
6 the people are doing.

7 MRS. AYLEN: Do you feel that that should be on
8 a provincial basis?

9 DR. le RICHE: We haven't decided. Somebody
10 should do it. We don't think there should be so many separate
11 efforts.

12 MRS. AYLEN: Well, what government agencies are
13 now concerned with statistics?

14 DR. le RICHE: All of them, really.

15 MRS. AYLEN: Health statistics?

16 DR. le RICHE: The Health Department is concerned
17 with some statistics; the Registrar-General is concerned with
18 other statistics; the Superintendent of Insurance is concerned
19 with some statistics; the voluntary prepayment plans are
20 involved with some statistics; the Ontario Hospital Association
21 is involved with other statistics; and there is no mechanism,
22 unless by individual effort, that these statistics all meet.

23 MRS. AYLEN: In other words, you want them
24 co-ordinated?

25 DR. le RICHE: I think so.



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25. DR. LE RICHE: ...



1 DR. HAMILTON: Do you mean that you want to set
2 up a new agency?

3 DR. le RICHE: No, I don't think a new agency
4 could be run. I think a reasonable place to run it would
5 probably be within the Health Department.

6 I don't know where it should be, Mr. Chairman.

7 DR. RHODES: I think in using the term "central
8 statistical agency," we did not exclude the fact that it might
9 be grafted on to an existing agency.

10 DR. HAMILTON: What you are really asking is
11 that there be a co-ordination applied to the statistical
12 services within the Government?

13 DR. le RICHE: Pertaining to health.

14 DR. RHODES: Now at least two different
15 Ministers are concerned; the Registrar-General and the Minister
16 of Health.

17 DR. le RICHE: And the Ontario Hospital Services
18 Commission is just about independent. They do report to the
19 Minister of Health.

20 MRS. AYLEN: Do some insurance companies have
21 their own?

22 DR. le RICHE: Yes, they all do. Mr. Chairman,
23 we feel that we should know, as taxpayers now, what is
24 happening to all this money that's going to be spent, and
25 whether it's well-spent. We want to know whether it's having



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MR. LEITCH: No, I don't think a new agency

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1 a good or a bad effect on the population. We would like to
2 know, or at least we taxpayers, I think the public has a right
3 to know how the money is being spent, whether it could be
4 better spent in other areas, and that's where you get a
5 research program which finds out the way things are going,
6 and strives to use this information for constructive purposes.

7 Otherwise a great deal of work could be going
8 on that nobody knows about.

9 MRS. AYLEN: You don't feel that that would
10 discourage individual donations?

11 DR. le RICHE: No. This has nothing to do with
12 individual donations.

13 MRS. AYLEN: From foundations?

14 DR. le RICHE: I don't think, madam, this has
15 got anything specifically to do with foundations.

16 DR. RHODES: One other aspect, which is rather
17 selfish, but we're a group of university teachers, and one of
18 our obligations is to train people in statistics. This is
19 extremely difficult, because we don't have ready access to the
20 very material on which these students are required to work.

21 We're quite conscious of the fact that in recom-
22 mending the establishment of a central statistical arrangement,
23 we don't know where the people would come from to start it.

5 24 This is a highly complicated field, and many of the people
25 should be physicians to begin with, and perhaps Dr. le Riche



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1 who is mainly interested in training these people, could add
2 a word.

3 DR. le RICHE: I feel that in the health
4 services there should be far more people trained in medicine
5 involved in the statistical services. They would have a better
6 understanding than people without that training, and this is
7 what we're trying to do, in a small way, but we think this
8 should be further developed.

9 We're not empire building. If you're running a
10 business, you should know what's happening in the business,
11 and that's what statistics are for.

12 This is the health business.

13 MR. MAJOR: Mr. Chairman, if this is needed for
14 teaching, maybe they should pay us the 1% to get the statistics
15 for them.

16 DR. RHODES: Yes.

17 DR. GALLOWAY: This is something which I feel
18 should be said in a serious way. I'm most impressed with this
19 brief. I think it's tremendous, and personally I want to thank
20 you for reminding us that we have to make recommendations in
21 this regard.

22 I also want to congratulate you. Having read
23 some of your other briefs, I know your attitude towards health
24 insurance, and the strength that you have shown indicates a
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30 insurance, and the strength that you have shown indicates a
31 great desire to make this Bill practicable and workable.



1 DR. RHODES: That's certainly the case, sir.

2 DR. GALLOWAY: And as an individual I certainly
3 appreciate it.

4 You've already answered some of the questions in
5 your preamble, which I was going to ask you, particularly in
6 regard to secondary prevention, and as you spoke I wondered
7 whether you were suggesting that this was an area for further
8 voluntary projects.

9 Is this your intent, rather than government?

10 DR. RHODES: Very much so, and I was provided
11 the information confidentially, Mr. Chairman. It may come to
12 you. A first-class study of this type has been done in
13 Ontario, just a short distance from Toronto, within the last
14 year, a mass-screening program, largely under the supervision
15 of the medical officer of health, making extensive use of
16 voluntary help to get interest going in the screening program,
17 to actually take a part in the clinics, and collecting the
18 final conclusions of the studies, which would not have been
19 possible without voluntary, unpaid help.

20 DR. GALLOWAY: The collection of the data, and
21 the research and analysis, it would seem to me that, being
22 mixed up in the business of insurance, that each of the
23 carriers, who undoubtedly have been keeping very strict statis-
24 tics of their own activities, so that they can develop policies
25 and premiums, and these things are of importance to them, and

possible without voluntary, unpaid help. final conclusions of the studies, which would not have been to actually take a part in the clinics, and collecting the voluntary help on the grounds that in the medical profession a mass-education program is not possible. I am sure that a first-class study of this type has been done in the information confidentially, Mr. Chairman. It may come to DR. RHODES: Very much so, and I was provided Is this your intent, rather than government?

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1 undoubtedly will be important to others, and therefore they
2 should be well-prepared to pay for this.

3 The type of statistical information which you
4 are interested in is that which will show us whether or not
5 the whole program is being satisfactory to the province and
6 the people. This, surely, is a responsibility of some of the
7 people, the Government, to assess the value of what private
8 enterprise is doing.

9 Is it, therefore, fair if this is for the bene-
10 fit of all the people, to suggest that the private plans
11 should be assessed for projects, some of which may be of no
12 value to them? Is this not more likely to be a government
13 responsibility?

14 DR. RHODES: Well, I think so. That's
15 perfectly true. I think, perhaps, tied in with this, was the
16 general philosophical belief that if a large sum of money is
17 spent on curative medicine that would more or less direct
18 encouragement of government, as it were, that at least some of
19 it should be siphoned off for something that would have more
20 permanent effect.

21 But I wouldn't disagree with what you said.

22 DR. GALLOWAY: The only other thing that I had
23 to mention in this regard was, again in the matter of finan-
24 cing, because it always appeared to me that university research
25 funds become available from various sources, and it's the



undoubtedly will be important to others, and therefore they
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DR. GALLOWAY: The only other thing that I had
in mind was that perhaps, again, in connection with this
kind of research is also important to the public, especially
in the sense of the public's interest in the results of the



1 university's responsibility to find them.

2 I can foresee that a government producing such
3 a statistical agency as you've suggested may want to get
4 further information, and make grants towards this, not only
5 the University of Toronto, but others. It would seem, however,
6 unfair to suggest that this agency be more or less compelled
7 to produce university funds, unless they had a particular
8 project they wanted done by them.

9 This really is my only point. I'm questioning
10 whether or not this agency should be forced to make grants to
11 universities. Much of this would be extremely valuable to you.

12 DR. RHODES: I don't think we had any element
13 of compulsion. In fact, I think it's fair to say that the
14 administrators of most universities prefer to receive money
15 for a definite purpose, and that's what we had in mind. For
16 instance, if Dr. le Riche were interested in studying some
17 particular application, he would send it to a particular
18 agency.

19 MR. NAYLOR: The Bill refers to setting up
20 Medical Carriers Incorporated, and if that body is looking
21 after a pooling arrangement they will, I'm sure, have to do a
22 certain amount of statistical work along the lines of what you
23 have suggested.

24 For one thing, they'll have to collect sufficient
25 information to determine from time to time what the maximum



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For one thing, they'll have to collect sufficient



1 premiums are to be, and whether they should be changed, and so
2 on. I think in that way it will have a central office, or
3 whatever you might call it, which will be doing, to some
4 extent, at least, the type of research - statistical research -
5 you refer to.

6 Of course, it will have to be limited, I
7 imagine, to some extent, by what can be paid for within the
8 monies available and the premium rates that are collected, but
9 it will operate in that field, I'm sure.

10 MISS CARPENTER: You mentioned that you wouldn't
11 see the value of periodic health examinations. Would you
12 consider that they were valuable for any age groups?

13 These are sections that we either approve or
14 disapprove.

15 DR. ROTH: Well, in our discussions on this
16 question, within the group of people who were preparing this
17 brief, we discussed this at some length. I don't think there's
18 any question in our minds of the value of periodic health
19 examinations; that is, if they are well done, that this would
20 be ideal.

21 Our concern is that with the resources that we
22 have, that is the medical resources that we have, there are
23 many other ways that we feel that we could use medical resources
24 more efficiently than we could in undertaking periodic health
25 examinations of all the population.



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1 Under an ideal system, as someone said in the
2 meeting, if we had a situation such as the President of the
3 United States has, with a personal physician, and almost a
4 complete physical examination week by week, or every two weeks,
5 this is an ideal situation.

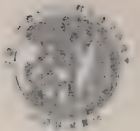
6 DR. HAMILTON: Do you take your students to see
7 the well-baby clinics?

8 DR. ROTH: Yes. I wish to add to this, the
9 second part of the question that was asked, do we see the
10 specific areas in life, specific age groups in life to which
11 this would be useful, and we suggested yes, there probably are
12 specific age groups of life at which these periodic health
13 examinations could be done usefully, and economically, and
14 feasibly.

15 MISS CARPENTER: I was wondering whether you
16 are prepared to give us a specific recommendation later on as
17 to which groups should be excluded, and which included, or are
18 we to accept it entirely?

19 DR. le RICHE: I think that we feel that there's
20 a certain faith which has developed in preventive health
21 examinations, which I don't think can be justified by the facts.

22 If they are very well done, they probably will
23 be very good, but we're not sure that widespread preventive
24 physical examinations of people at certain intervals are going
25 to do as much as some people think they are going to do.



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6 1 This is my own observation. It's very interes-
2 ting that it's very often preventive medical people who are the
3 most enthusiastic about annual physical examinations. When
4 you talk to the internists, they're not. Well, after all, it's
5 the internists who see the sick people all the time, and if
6 these examinations are as good as the preventive medical people
7 state they are, then surely the physicians would have come to
8 the same conclusion.

9 DR. HAMILTON: Would your group state, or give
10 us in writing a statement that well-baby clinics should be
11 continued or should be abolished?

12 DR. RHODES: Certainly, sir. We will take this
13 under advisement.

14 MISS CARPENTER: Would you give consideration to
15 people over 45, or over 65, or what age group do you think
16 this would be of value to?

17 DR. GALLOWAY: I wonder if we're really asking
18 Dr. Rhodes and his group here to give us some information that
19 they really can give us?

20 Do you have such information?

21 DR. le RICHE: I think it will be medical infor-
22 mation.

23 DR. RHODES: I'm afraid it will largely be an
24 opinion. It's really based on the take rate. That is, if you
25 examine a hundred babies, how many do you find to be sick? If



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interesting observation. It's a very interesting observation.

DR. HAMILTON: Would your group state, or give

the same conclusion. It's a very interesting observation.

continued or should be discontinued?

DR. RHODES: Certainly, sir. We will take this

question. It's a very interesting observation. It's a very

MISS CARPENTIER: Would you give consideration

people over 45, or over 65, or what age group do you think

this would be of value to?

DR. GALLOWAY: I wonder if we're really asking

Dr. Rhodes and his group here to give us some information that

they really can give us?

Do you have such information?

DR. LE RICH: I think it will be medical and

DR. RHODES: I'm afraid it will largely be an

opinion. It's really based on the same rate. That is, if you

have a certain number of people, you have a certain rate of



1 you examine a hundred old people, how many do you find to be
2 sick?

3 I think everyone here realizes that you will
4 find more sick in the old people.

5 DR. le RICHE: The importance is really to
6 measure the efficacy of preventive health examinations of the
7 population. This has been shown to be good in a lot of cases.
8 It has been shown to be good in cancer and so on, but I think
9 there is a certain amount of folk lore connected with this.

/dpw 10 Many of these other programs of preventive health examinations,
11 I think, should be much more critically examined. I think we
12 should examine the situation more critically.

13 DR. HAMILTON: I think the statement is here
14 that periodical health examinations are not worth doing and
15 this prompted the question that I asked. That is the only
16 reason the question was asked.

17 DR. RHODES: Yes - not worth doing. I do not
18 think that is what we meant. I think they are worth doing,
19 if there was unlimited medical time. But there is hardly,
20 anywhere in this province, unlimited medical time.

21 THE CHAIRMAN: That is the point that I think
22 was asked here. I do not think that you said preventive
23 examinations should be tossed out entirely?

24 DR. RHODES: No.

25 THE CHAIRMAN: But that there are not enough



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It is a question of whether or not it is worth doing.

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DR. RHODES: No.

THE CHAIRMAN: But that there are not enough



1 physicians in the country to do them?

2 DR. le RICHE: That is correct.

3 MR. SIMON: If I may share my own personal
4 experience with you, I was a member of a group and there were
5 800 in the group. It was a union group. Some years ago they
6 instituted an annual medical examination. The first year we
7 went through, they detected one person with consumption,
8 another one with cancer, and those people had been to a doctor
9 for years. There were other minor sicknesses, and so on. So,
10 to me, it was an eye-opener. I do not think this is any indica-
11 tion of the general trend; I do not know.

12 DR. RHODES: I think that many of the union
13 groups have pioneered in doing adequate comprehensive examina-
14 tions on a highly organized basis of having specialists
15 available to do the examinations. This is probably more fully
16 than is very often meant by the term "periodic health examina-
17 tion."

18 THE CHAIRMAN: Are there any further questions
19 of the members of the Enquiry who are left? We apologize that
20 our numbers have diminished somewhat since we started, but it
21 was not anticipated that it would run this long today. How-
22 ever, one particular submission ran over the time allotted for
23 it. Do you have any further comments?

24 DR. le RICHE: No, sir. Thank you for the
25 privilege of appearing here.



physicians in the country to do them?

DR. LE RICHE: That is correct.

MR. SIMON: If I may share my own personal

experience with you I am a member of a group of about 100
physicians in the city of Toronto. The first time we
met, we discussed the general situation.

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THE CHAIRMAN: Are there any further question
of the members of the Body who are left? We apologize th
was not anticipated that it would run this long today. Now-

15. Do you have any further comments?

DR. LE RICHE: No, sir. Thank you for the



1 THE CHAIRMAN: We are very pleased to have heard
2 from you. Thank you.

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5 --- Adjournment.

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